

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 27, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001158	Date of Injury:	07/20/2010
Claim Number:	[REDACTED]	Application Received:	07/16/2015
Assignment Date:	08/25/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/09/2015 – 04/09/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	73221-TC-RT		

Dear [REDACTED]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

**Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$1,547.02 in additional reimbursement for a total of \$1,742.02. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$1,742.02** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

Paul Manchester, M.D., M.P.H.  
Medical Director

Cc: [REDACTED]  
[REDACTED]

## **DOCUMENTS REVIEWED**

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- PPO Contract

## **HOW THE IBR FINAL DETERMINATION WAS MADE**

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

## ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider seeking additional Contractual remuneration for 73221, RT – TC MRI performed on 04/09/2015.**
- The Claims Administrator based reimbursement on “PPO Recommended Allowance.”
- Itemized Services presented on UB-04, Bill Type “851,” Ambulatory Surgery, Intermediate Care, Level I.
- **§ 9789.32 (4)(f)** Critical access hospitals and hospitals that are excluded from acute PPS **are exempt** from this fee schedule.
- Exempt from OMFS includes any and all services.
- Contractual Agreement Submitted for IBR indicates “88.54% of covered billed charges.”
- EORs reflect payment for 73221, thus indicating a covered service.
- Reimbursement, if applicable, is then dictated by a Contractual Obligation.
- **LC §5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates. Except as provided in subdivision (b) of Section 5307.1, the official medical fee schedule shall establish maximum reimbursement rates for all medical services for injuries subject to this division provided by a health care provider or health care facility licensed pursuant to Section 1250 of the Health and Safety Code other than those specified in contracts subject to this section.
- **Provider’s OMFS exemption status defaults to reimbursement of 100 % of billed charges or, if applicable, a Contractual Obligation pursuant to LC §5307.11**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 73221-RT-TC in accordance with existing Contractual Agreement between the Provider and the Claims Administrator.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 73221**

<b>Date of Service:</b> 04/09/2015 HOPPS						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
73221	\$2,054.00	\$271.59	\$1,547.02	1	\$1,818.61	<b>\$1,547.02 Due Provider Refer to Analysis</b>

Copy to:

[REDACTED]

Copy to:

[REDACTED]