
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 6, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000605	Date of Injury:	05/26/2015
Claim Number:	[REDACTED]	Application Received:	04/14/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	Rev Code 250, CPT Codes 71020, 20101, 90471-59, 99283-25, and 90715		

[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 \$2,617.99 in additional reimbursement for a total of \$2,812.99.

The Claim Administrator is required to reimburse the Provider a total of \$2,812.99 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, MD MPH
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
- Official Medical Fee Schedule
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 reimbursement for billed services performed on date of service 05/26/2015.**
- Services billed on UB04 claim form with bill type 131.
- Claims Administrator issued reimbursement for the billed codes with indication “this charge was adjusted to comply with the rate and rules of the contract indicated”.
- Title 8, CCR 9789.32 (a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014.
- § 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.**

- Submitted PPO contract documents under 5/02 Bills by Facility: “(on an industry-accepted form such as UB-82)...The bills may reflect Facility’s usual and customary charges, but payment for Covered Services shall be in accordance with the fees set forth in the Fee Schedule in Exhibit A.”
- Exhibit A Fee Schedule: “Percentage Allowance from Billed Charges: Outpatient Charges 0%.”
- No other PPO contract documentation was received from the Claims Administrator.
- In review of the PPO Contract and EOR, it does not appear the reimbursement by the Claims Administrator was based on the submitted PPO contract.
- Based on submitted PPO contract, additional reimbursement is recommended for the disputed billed services for date of service 5/26/2015.

DETERMINATION OF ISSUE IN DISPUTE: Rev Code 250, CPT Codes 71020, 20101, 90471-59, 99283-25, and 90715.

Date of Service 05/26/2015					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
Codes Billed	\$3,606.40	\$988.41	\$2,617.99	\$3,606.40	PPO Contract - \$2,617.99 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]