

**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**

June 6, 2016

██████████  
██████████  
██████████  
██████████

IBR Case Number:	CB16-0000761	Date of Injury:	06/21/2003
Claim Number:	██████████	Application Received:	05/06/2016
Claims Administrator:	██████████		
Date(s) of service:	11/10/2015		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	99215 and WC002		

Dear ██████████:

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 \$160.73 in additional reimbursement for a total of \$355.73. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$355.73 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,

Maximus IBR

cc: ██████████  
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## 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
- Negotiated contracted rates: 10% PPO Discount
- National Correct Coding Initiatives

## 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 remuneration of codes 99215 and WC002 for date of service 11/10/2015.
- Claims Administrator denied codes with rationale “payment is denied, service not authorized.”
- Communication dated 02/10/2016 from Claims Administrator to Provider shows “Retro Request for Office Visit DOS 11/10/15/Approved per UR nurse”
- § 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.
- Provider billed 99215, evaluation and management of an established patient.
- Provider’s report submitted states “patient returns today for an interval follow-up visit regarding her ongoing chronic low back pain.”

- Authorization dated 2/10/2016 is contract in nature. Reimbursement of 99215 is warranted.
- Provider also billed code WC002 – Primary Treating Physician’s Progress Report (PR-2).
- Authorization submitted approved office visit and did not include any other services including codes WC002.
- Reimbursement WC002 is not warranted.
- Provider states reimbursement agreement of 90%.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99215

<b>Date of Service:</b> 11/10/2015						
<b>Physician Services</b>						
<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>
99215	\$240.00	\$0.00	\$240.00	1	\$160.73	<b>\$160.73 due to Provider</b>

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