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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 12, 2014

[redacted]

IBR Case Number:	CB14-0001285	**Date of Injury:**	12/14/2010
Claim Number:	[redacted]	**Application Received:**	09/05/2014
Claims Administrator:	[redacted]	**Assignment Date:**	10/07/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99499 (10 units)		

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 $250.00 for the review cost and $10,000.00 in additional reimbursement for a total of $10,250.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $10250.00 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,

[redacted]
Chief Coding Reviewer

cc: [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
- Negotiated contracted rates: No Contract
- Other: Request for Authorization dated 6/4/14

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**: Denial of CPT code 99499 (10 units).
- The case file includes a request for authorization dated 6/4/14 which includes a reimbursement agreement indicating that amount to be reimbursed for the service. A reimbursement rate of $1000.00/day (unit) is noted.
- The Provider billed for $1000.00/day (unit).
- The Claim Administrator provided authorization of the services dated 6/5/14. There is no other documentation of the amount to be paid or negotiation of amount by the Claim Administrator of less than the authorization amount.
- Reimbursement to be set at the amount established prior to the service on authorization request.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99499 is to be made at $1,000.00 per unit. A total of $10,000.00 is due to the Provider.

Date of Service: 6/2/14-6/13/14							
Service	**Provider**	**Plan**	**Dispute**	**Asst**	**Mult**	**Workers'**	**Notes**

Code	Billed	Allowed	Amount	Surg	Surg	Comp Allowed Amt.	
99499 (10 units)	$10,000.00	$0.00	$10000.00	N/A	N/A	$10,000.00	**DISPUTED SERVICE**: Additional amount of $10,000.00 due to the Provider.

Copy to:

[redacted]

Copy to:

[redacted]