

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 22, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001297	Date of Injury:	12/17/2002
Claim Number:	[Redacted]	Application Received:	09/08/2014
Claims Administrator:	[Redacted]	Assignment Date:	10/13/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64632, 99215, WC002 and NDCs 55111015810, 00603388732 and 00603646932		

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 \$679.42 in additional reimbursement for a total of \$929.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$929.42 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]
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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: CPT Guidelines

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 is dissatisfied with denial of codes NDCs 55111015810, 00603388732 and 00603646932, CPTs 64632, 99215 and WC002 for date of service 01/14/2014
- Claims Administrator denied codes indicating on the Explanation of Review “This charge is denied as the service was not authorized during the utilization review process.”
- Authorization submitted shows a retro-authorization for date of service 01/14/2014.
- Provider submitted a Primary Treating Physician/Comprehensive Interim Evaluation, Treatment and Report. Provider billed a 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of high complexity. However, documentation of the report submitted does not meet the criteria of a 99215 but rather a 99213 -Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Therefore, reimbursement for the E/M code will be based on the OMFS for 99213.

- Provider also documents in the report the nerve blocks he performed on the patient. Therefore reimbursement of code 64632 is warranted.
- Provider also billed NDC codes 55111015810, 00603388732 and 00603646932. Provider did not document in the report any medications dispensed nor was an authorization for billed NDCs found in this review. Therefore, reimbursement of NDCs 55111015810, 00603388732 and 00603646932 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99215(down coded to 99213), WC002 and 64632 is warranted.

Date of Service: 01/14/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99213 (99215)	\$167.15	\$0.00	\$167.15	1	N/A	\$84.99	DISPUTED SERVICE: Allow reimbursement \$84.99
WC002	\$11.91	\$0.00	\$11.91	1	N/A	\$11.91	DISPUTED SERVICE: Allow reimbursement \$11.91
64632	\$582.52	\$0.00	\$582.52	4	N/A	\$582.52	DISPUTED SERVICE: Allow reimbursement \$582.52
NDC 5511101 5810	\$180.60	\$0.00	\$180.60	30	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
NDC 0060338 8732	\$42.60	\$0.00	\$42.60	60	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
NDC 0060364 6932	\$9.60	\$0.00	\$9.60	30	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

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