

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 30, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000348	Date of Injury:	06/01/2005
Claim Number:	[Redacted]	Application Received:	03/11/2014
Claims Administrator:	[Redacted]	Assignment Date:	11/05/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	95044 and 99212		

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 \$335.00 for the review cost and \$1893.60 in additional reimbursement for a total of \$2228.60. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2228.60 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: PPO Contract Discount 10%
- 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 is dissatisfied with denial of code 95044 and 99212.
- Claims Administrator denied code indicating on the Explanation of Review ‘This procedure requires prior authorization and none was identified.’
- Documentation received included a request for Provider to act as the Agreed Medical Examiner on an injured worker who has had a skin condition. Request came from the attorney which states ‘Please accept this letter as conferring authorization for you to conduct any testing you feel is necessary’ and ‘Please address the applicant’s allegations of injury within your specialty of dermatology’
- Provider performed a skin patch test on the injured worker due to the skin condition that has developed over the years and is a part of the injured worker’s case.
- The authorization does state for the Agreed Medical Evaluator to perform any tests necessary and therefore, reimbursement of code 95044 is warranted.
- The request does not state any other visits are authorized including a revisit for the reading of any tests. Therefore, no reimbursement is warranted for code 99212.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 95044 is recommended.

Date of Service: 10/29/2013							
Physician Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
95044	\$5000.00	\$0.00	\$5000.00	200	N/A	\$1893.60	DISPUTED SERVICE: Allow reimbursement \$1893.60
99212	\$75.00	\$0.00	\$75.00	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

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