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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 22, 2015

[redacted]

IBR Case Number:	CB14-0001574	Date of Injury:	08/27/2012
Claim Number:	[redacted]	Application Received:	10/20/2014
Claims Administrator:	[redacted]		
Assigned Date:	2/24/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	17999		

[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 $1850.00 in additional reimbursement for a total of $2100.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $2100.00 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,

Paul Manchester, MD, MPH
Medical Director

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:
- 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 reimbursement of code 17999 for multiple dates of service 6/4/2014, 6/9/2014, 6/16/2014, 6/24/2014, 7/2/2014, 7/16/2014, 7/23/2014 and 8/6/2014.
- Claims administrator reimbursed code for multiple dates of service indicating on the Explanation of Review "This charge was adjusted to comply with the rate and rules of the contract indicated."
- Provider states that a contract between he and claims administrator does not exist. Claims administrator did not submit any contract for this review. Therefore, as a contractual agreement between the Provider and the Claims Administrator does not exist; OMFS will be utilized to calculate reimbursement.
- OMFS allows for Unlisted Procedure Codes to be reimbursed by "By Report."
- §9789.12.4 (c) "In determining the value of a By Report procedure, consideration may be given to the value assigned to a comparable procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed."
- There is no allowance listed under the OMFS for the billed procedure code 17799 or, more specifically, Intense Light Pulse treatment, and a CPT Code has yet to be formulated for this service.

- Authorization signed by the Claims Administrator states the Providers Usual and Customary fee of $800.00 per IPL treatment.
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for CPT 17999 Unlisted Procedure representing services for Intense Light Pulse treatment for multiple dates of service.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 17999 is recommended.

Dates of Service: 6/4/2014, 6/9/2014, 6/16/2014, 6/24/2014, 7/2/2014, 7/16/2014, 7/23/2014 and 8/6/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
17999	$6400.00	$4800.00	$1850.00	8	N/A	$6400.00	**DISPUTED SERVICE**: Allow reimbursement $1850.00

Copy to:

[redacted]

Copy to:

[redacted]