

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 13, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001604	Date of Injury:	05/16/2013
Claim Number:	[Redacted]	Application Received:	10/24/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99203-57 and 26765		

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.

IBR Assignment: 12/03/2014

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 \$93.47 in additional reimbursement for a total of \$343.47. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$343.47 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]
[Redacted]

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 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 reimbursement of codes 99203-57 and 26765.
- **Provider's IBR application shows 05/16/2014 as date of service.** Claim submitted, along with documentation and Explanation of Review all show date of service as 05/16/2013. **Date of service for this review is 05/16/2013.**
- Claims administrator denied code 99203-57 indicating on the Explanation of Review "Visit falls within a surgery follow-up period"
- Injured worker sustained a finger injury on May 16, 2013. Documentation received included an Emergency Orthopedic Consultation report describing the workers injury and the decision to have surgery that day.
- The modifier -57 appended to the New Patient visit shows the decision for surgery at the time of the visit. Therefore, reimbursement of code 99203-59 is warranted.
- Provider billed code 26765, Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each. Provider documents internal fixation of injured small left finger.
- Claims administrator reimbursed \$342.78 indicating on the Explanation of Review "This charge was adjusted to comply with the rate and rules of the contract indicated." PPO contract shows a 10% discount to be applied to workers' compensation services. The

Official Medical Fee Schedule allowance for code 26765 shows \$372.59. It appears that claims administrator only took an 8% discount and therefore, additional reimbursement of code 26765 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99203-57 is recommended.

Date of Service: 05/16/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99203-57	\$125.39	\$0.00	\$125.39	1	N/A	\$93.47	DISPUTED SERVICE: Allow reimbursement \$93.47
26765	\$844.22	\$342.78	\$501.44	1	N/A	\$335.33	DISPUTED SERVICE: No reimbursement recommended.

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