

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 9, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001683	Date of Injury:	04/10/2014
Claim Number:	[REDACTED]	Application Received:	11/10/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/09/2014 – 05/09/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	73721-RT		

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 \$255.00 for the review cost and \$209.93 in additional reimbursement for a total of \$459.93. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$459.93 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, M.D., M.P.H.
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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 seeking full remuneration for 73721 MRI service to Injured Worker on 05/09/2014.
- Claims Administrator reimbursement rational: “The recommended allowance is based on the value for the technical component of the service performed.”
- Initial EOR 06/09/2014 reflects allowance of 322.07, 100% OMFS 2014/2015 for dates on or after 09/01/2014.
- Subsequent EOR 10/06/2014 reflects no additional allowance.
- 2014/2015 OMFS Hospital Outpatient Services effective date is 09/01/2014.
- Date of Service reflected on UB-04 is 05/09/2014.
- Services performed before OMFS effective date of 09/01/2014.
- Additional reimbursement is warranted for 73721 Under OMFS Prior to 09/01/2014.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 73721

Date of Service:						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
73721	\$4,141.32	\$322.07	\$209.93	1	\$532.00	OMFS – Reimbursed Amount = \$209.93 Due Provider

Copy to:

██████████
 ████████████████████
 ████████████████████████████████

Copy to:

██
 ██
 ██