

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 14, 2015

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000077	Date of Injury:	08/27/2012
Claim Number:	[REDACTED]	Application Received:	01/20/2015
Claims Administrator:	[REDACTED]	Assignment Date:	02/23/2015
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	17999		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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]
[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

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 additional remuneration for 17999 Unlisted procedure, skin, mucous membrane and subcutaneous tissue performed on Date of Service 10/02/2014.**
- EOR reflects Claims Administrator's reimbursement rational as follows:
 - This charge was adjusted to comply with the rate and rules of the contract indicates.
- EOR indicates a PPO reduction of \$75.00 from 17999 \$300.00 charge.
- IBR Application reflects Claims Administrator Listed on 1st and 2nd EOR.
- EOR indicates Claims Administrator Utilizes a contracting agent for a Multiple Provider Network (MPN) Network Product.
- Documentation from the Provider reflects the Provider is unaware of a contract with an agent other than the Claims Administrator listed on the EOR.
- The Provider presented communication from his Contract's Manager and the Claims Administrator's MPN contracting agent. The presented communication indicates the Provider has yet to terminate a contractual relationship to MPN.
- No other communication from the Claims Administrator or the Claims Administrator's Contracting Agent presented to confirm the Provider is not a part of the MPN plan.
- Authorization for treatment signed by Claims Administrator reflects authorization for treatment. Authorization does not reflect Claim's Administrator's contractual agreement for reimbursement of 17999.

- **Labor Code § 4611 states:** (a) When a contracting agent sells, leases, or transfers a health provider’s contract to a payor, the rights and obligations of the Provider shall be governed by the underlying contract between the health care provider and contracting agent.
- **Pursuant to LC § 5307.11** – “the medical fee schedule shall not apply to the contracted reimbursement rates.” California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:
- **LC § 5307.11 states:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, **the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.**
- **§ 9792.5.7 (b)** Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code 5307.11 shall be resolved before seeking independent bill review.
- Based on the aforementioned guidelines, IBR is prohibited from resolving conflicts contractual in nature.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 17999

Date of Service: 10/02/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
17999	\$300.00	\$240.00	\$60.00	1	N/A	\$240.00	Refer to Analysis

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