

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 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000269	Date of Injury:	06/27/2011
Claim Number:	[Redacted]	Application Received:	02/24/2015
Claims Administrator:	[Redacted]		
Date Assigned:	3/18/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99213, 73610-RT and WC002		

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 \$195.00 for the review cost and \$75.69 in additional reimbursement for a total of \$270.69. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$270.69 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]
[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
- 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 99213, 73610-RT and WC002
- Claims Administrator reimbursed \$85.91 indicating on the Explanation of Review a PPO reduction was applied to all three codes. Provider disputes a PPO contract agreement with the Claims Administrator.
- Documentation received for this review included a letter from the Provider to the Claims Administrator dated August 1, 2014 stating they do not have a contract with this Claims Administrator. They requested a copy of a contract if one existed.
- Letter dated 10/1/2014 from Claims Administrator's Contract Service Operations stating they would be in contact with the Provider.
- Provider's Request for Second Bill Review dated 1/9/2015 states a request for the Claims Administrator to provide a full contract signed by on the Provider's officers. 2nd EOR states "No additional reimbursement allowed after review of appeal/reconsideration"
- Nothing was received by the Claims Administrator regarding any PPO contract.
- Based on information reviewed, as Provider is disputing a PPO contract exists and Claims Administrator did not supply a contract, additional reimbursement for codes 99213, 73610-RT and WC002 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes 99213, 73610-RT and WC002 is recommended

Date of Service: 9/23/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99213	\$120.00	\$47.30	\$37.69	1	N/A	\$84.99	DISPUTED SERVICE: Allow reimbursement \$37.69
73610-RT	\$90.00	\$31.46	\$26.09	1	N/A	\$57.55	DISPUTED SERVICE: Allow reimbursement \$26.09
WC002	\$11.91	\$7.15	\$4.76	1	N/A	\$11.91	DISPUTED SERVICE: Allow reimbursement \$4.76

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