

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 18, 2015

[Redacted]

IBR Case Number:	CB15-0001948	Date of Injury:	04/28/2015
Claim Number:	[Redacted]	Application Received:	10/20/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	04/28/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99283 and 12011		

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 \$37.43 in additional reimbursement for a total of \$232.43. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$232.43 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: PPO Contract Agreement
- National Correct Coding Initiatives
- 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 additional reimbursement for codes 99283 and 12011 for date of service 04/28/2015**
- The initial EOR resulted in reimbursement for both codes in the amount \$300.27.
- Provider states Contract between the two parties is 97% reimbursement.
- Title 8, CCR 9789.32 (a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014.
- For services rendered on or after September 1, 2014, only hospitals may charge or collect a facility fee for emergency room visits, Facility Only Services, and Other Services. Only hospital outpatient departments and ambulatory surgical centers as defined in Section 9789.30(o) and Section 9789.30(c) may charge or collect a facility fee for surgical services provided on an outpatient basis. Facility fees are not payable to an ambulatory surgical center for any services that are not an integral part of a surgical service.
- For services rendered on or after September 1, 2014: APC relative weight x adjusted conversion factor x 1.212 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative.

- Opportunity for Claims Administrator to Dispute Eligibility letter was sent on 10/21/2015. A response from Claims Administrator was not received for this review.
- Based on the above mentioned rules, guidelines and submitted medical record, additional reimbursement is warranted for the billed codes: 99283 and 12011.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Recommended additional reimbursement of codes: 99283 and 12011.

Date of Service 04/28/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99283 and 12011	\$1210.00	\$300.27	\$37.43	N/A	\$337.79	\$37.43 Due to Provider

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