

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 18, 2015

[Redacted]

| | | | |
|-----------------------|---|-----------------------|------------|
| IBR Case Number: | CB15-0001956 | Date of Injury: | 06/16/2003 |
| Claim Number: | [Redacted] | Application Received: | 10/07/2015 |
| Claims Administrator: | [Redacted] | | |
| Date(s) of service: | 06/30/2015 | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 99215-25, 99070 x 30, 99070 x 60, WC002, 96101-59 | | |

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 \$190.60 in additional reimbursement for a total of \$385.60. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$385.60** 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]

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
- OMFS

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 remuneration for 99215-25, 99070 x 30, 99070 x 60, WC002 and 96101-59 performed on 06/30/2015.**
- Contractual Agreement not submitted for IBR.
- Documentation dated March 11, 2015 from Claims Administrator to Provider stating he is the Primary Treating Physician for the injured worker.
- Pursuant Title 8 Section 9785: (g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the “Request for Authorization”
- Documentation dated July 18, 2015 from Claims Administrator to Provider states services denied as not authorized. Also documented by Claims Administrator: “The medications dispensed were not authorized. Furthermore, the doctor is not authorized to dispense the medications from his office. All medications must be processed through First Scripts.”
- Reimbursement of 99070 x 30, 99070 x 60 and 96101-59 is not warranted as authorization for services was not identified in this review.
- Follow-up evaluation and management services for accepted injury do not require authorization. EOR’s do not reflect dispute of reported ICD.9 codes.
- WC002 – Primary Treating Physician’s Progress Report (PR-2), documents services performed on 6/30/2015.
- **Based on the aforementioned documentation and guidelines, reimbursement for defined Evaluation and Management service, 99215-25 and WC002 is recommended.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99215-25 and WC002

| Date of Service: 06/30/2015 | | | | | | |
|------------------------------------|------------------------|---------------------|-----------------------|--------------|-----------------------------------|---------------------------------|
| Physician Services | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes |
| 99215-25 | \$240.00 | \$0.00 | \$237.17 | 1 | \$178.59 | \$178.59 Due to Provider |
| WC002 | \$250.00 | \$0.00 | \$250.00 | 1 | \$12.01 | \$12.01 Due to Provider |

Copy to:

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[REDACTED]
[REDACTED]

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