

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 14, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002137	Date of Injury:	03/19/2014
Claim Number:	[REDACTED]	Application Received:	11/20/2015
Assignment Date:	12/10/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/15/2015 – 07/15/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99070		

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, 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
- Contractual Agreement
- 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 99070 x 60 Units for date of service 07/15/2015.**
- The Claims Administrator denied services with the following rationale: “The value of this service is included in the value of another service performed on the same day,” and “the service not provided or authorized by designated (network/primary care) providers.”
- CPT 99070, a status indicator “**B**,” and is **bundled** into the main procedure performed and is **not separately reimbursable**.
- Incorrect CPT code for dispensed medication with expected reimbursement.
- **CCR Article 5.5.0. Rules § 9792.5.7.** Requesting Independent Bill Review (b)(2) **The proper selection of an analogous code** or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- CMS 1500 indicates the following line items **submitted** by the Provider:
 - Established Patient Office Visit
 - PR-2 Report
 - 99070 Supplies & Materials, 60 units
- **Abstracted** information from Provider’s dictation indicate the following medication:
 - Dispensed Diclofenac ER 100mg, #60
- 99070 is not the correct reimbursement code for dispensed medication. HCPCS Code S5000 Prescription drug, generic, is a “By Report” code utilized for medication dispensed in an Outpatient Office setting.
- Unless otherwise stated in the Contractual Agreement, prescriptions **require prior-authorization**.
- **Contractual Agreement Page 6, section “2.12,” under “Drug Formulary/Generic Substitution,”** indicates “when prescribing” and does not indicate “when dispensed” or that the Provider is an authorized vendor/provider for pharmaceuticals.
- **October 30, 2015** communication from the Claims Administrator indicates ‘the service not provided or authorized **by designated (network/primary care) providers.**’
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 99070.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99070

Date of Service: 07/15/2015 Physician/Pharmacy						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99070	\$147.70	\$0.00	\$147.60	60	\$0.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]