

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 25, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000550	Date of Injury:	03/21/2008
Claim Number:	[REDACTED]	Application Received:	04/13/2015
Assignment Date:	05/08/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/03/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	WC004 and 99358		

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 \$329.39 in additional reimbursement for a total of \$4524.39. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$524.39** 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]  
[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 WC004 and 99358 Prolonged Services without face to face contact and WC004 Primary Treating Physician Permanent and Stationary Report performed 11/03/2014.**
- EOR reflects Claims Administrator's \$0.00 reimbursement rational as follows: "The billings are for self-procured medical treatment and defendant disputes the reasonableness or necessity of the treatment and charges thereof."
- Authorization for aforementioned services and relating fees signed by Claims Administrator on October 22, 2014 as "Approved."
- **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.**

- Authorization dated 10/17/2014 and signed by the Claims Administrator on 10/22/2014 for Date of Service 11/03/2014 is contractual in nature. As such, reimbursement is warranted pursuant to LC § 5307.11 for 99358 and WC004.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99358 and WC004**

<b>Date of Service:</b> 11/03/2014							
<b>Med-Legal Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99358	\$290.70	\$0.000	\$290.70	N/A	1	\$290.70	<b>Refer to Analysis</b>
WC004	\$38.69	\$0.00	\$38.69	N/A	1	\$38.69	<b>Refer to Analysis</b>

Copy to:

[REDACTED]

Copy to:

[REDACTED]