

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 15, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000902	Date of Injury:	08//02/1992
Claim Number:	[Redacted]	Application Received:	06/03/2015
Assignment Date:	07/03/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	02/25/2015 – 02/25/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	V5257-LT, V5257-RT		

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
- 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 V5257-LT & V5257-RT hearing aids, provided to Injured Worker 02/25/2015.**
- Claims Administrator reimbursed the Provider based on Provider Contract.
- Communication from Claims Administrator 06/22/2014 indicated Provider was reimbursed in accordance with PPO contract.
- Provider RFA reflects Provider's usual and customary fee.
- Authorization indicates hearing aids as "certified" but does not indicate or reference the Provider's usual and customary fee.
- Contractual agreement not submitted for IBR.
- **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.**

- Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for V5257-LT & V5257-RT.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106 services.

Date of Service: 01/06/2014							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
V5257-LT & V5257-RT	\$5,400.00	\$3,240.00	\$2,160.00	N/A	1	\$3,240.00	PPO Contract

Copy to:

[Redacted]

Copy to:

[Redacted]