

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 21, 2015

[Redacted]

IBR Case Number:	CB15-0000989	Date of Injury:	12/09/2013
Claim Number:	[Redacted]	Application Received:	06/17/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	12/09/2013		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99283		

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 \$202.20 in additional reimbursement for a total of \$397.20. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$397.20 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: American Medical Association 1997 Current Procedural Terminology

## 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 is dissatisfied with denial of 99283, Emergency department visit for the evaluation and management of a patient.
- Claims Administrator denied code indicating on the Explanation of Review “Per CCI Edits, the value of this procedure is included in the value of the comprehensive procedure”
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers’ Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers’ Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Title 8, California Code of Regulations Chapter 4.5, Division of Workers’ Compensation Subchapter 1 Administrative Director-Administrative Rules Article 5.3 Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers Services on or after January 1, 2004 (The underlined text reflects amendments made in accordance with the acting administrative director Order effective April 1, 2013)
- Section 9789.32. Applicability. (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. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10021-

69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure.

- For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).
- Based on 1997 guidelines and regulations, reimbursement of 99283 is warranted.
- EOR received reflects a 2% PPO contract discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99283**

<b>Date of Service:</b> 12/09/2013						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99283	\$1683.00	\$0.00	\$206.33	N/A	\$202.20	<b>DISPUTED SERVICE:</b> Allow reimbursement \$202.20

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