

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 8, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001996	Date of Injury:	02/18/2014
Claim Number:	[REDACTED]	Application	12/29/2014
Claims	[REDACTED]		
Date(s) of service:	07/23/2014 – 07/23/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	WC002		

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

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 full OMFS remuneration for WC002 Primary Treating Physician Progress Report, performed on date of service 07/23/2014.**
- EOR reflects Claims Administrator's reimbursement rational as follows:
 - The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the schedule allowance.
 - This charge was adjusted to comply with the rate and rules of the contract indicates.
- EOR indicates Provider was reimbursed for WC002
- IBR Application reflects Claims Administrator Listed on 1st and 2nd EOR.
- EOR indicates Claims Administrator Utilizes a contracting agent for PPO Network.
- IBR Application indicates Provider is unaware of contractual agreement.
- **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.
- **Research** on the Claims Administrator's web-site listed on the IBR application indicates the contracting agent and lists the Provider as part of the MPN.
- **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

