

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 13, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000626	Date of Injury:	09/28/2013
Claim Number:	[REDACTED]	Application Received:	04/18/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/28/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215-25, WC002, 20553, S002, J3490, and J1030		

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 \$281.06 in additional reimbursement for a total of \$476.06. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$476.06** 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 99215-25, WC002, 20553, S002, J3490, and J1030 performed on 12/28/2015.**
- The Claims Administrator denied services due “not authorized.”
- Opportunity to Dispute communicated to Claims Administrator on 4/20/2016, response not yet received.
- Retro-Authorization dated 2/21/2016 indicates the following as “medically necessary” and “approved” for 12/28/2015:
  - Office Visit
  - Trigger Point Injections Performed (Bupivacaine), 20553
- J3490, J1030 and WC002 were not authorized services by Claims Administrator. Therefore, reimbursement of these codes is not warranted.
- 2<sup>nd</sup> EOR submitted does not show S0020 as having been reviewed. Provider does not mention having tried to receive a 2<sup>nd</sup> review for this code and therefore reimbursement of S0020 is not warranted.
- § 9792.5.7 (b) unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code 5307.11 shall be resolved before seeking independent bill review.
- CPT 99215 requires a Comprehensive History/ Comprehensive Exam/ High Complexity. The Injured Worker presented for Trigger Point Injections. However, the Provider examined and addressed injured worker’s “neck and shoulder pain.” Abstracted data from the submitted PR-2 report indicates the following service:

- Expanded Problem Focused History
- Expanded Problem Focused Examination
- Medical Decision Making: Moderate
- Exp. PF / Exp. PF/ Moderate = 99213
- Separate Trigger Point Injection(s) report submitted documenting 20553 performed.
- **Based on the aforementioned documentation and guidelines, reimbursement for 99213, and S0020 is indicated.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99215-25, WC002, 20553, S002, J3490, and J1030**

Date of Service: 12/28/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99215-25	\$240.00	\$0.00	\$178.59	1	\$178.59	Refer to Analysis
20553	\$280.00	\$0.00	\$102.47	1	\$102.47	Refer to Analysis

Copy to:

██████████  
 ██████████  
 ██████████

Copy to:

██  
 ██  
 ██