

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 22, 2016

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

IBR Case Number:	CB16-0000317	Date of Injury:	02/12/2013
Claim Number:	[REDACTED]	Application Received:	02/25/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/01/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	96367, 96368, 80053, 85027, 96411, 96413, 96416, and 99213-25		

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 \$2,794.64 in additional reimbursement for a total of \$2,989.64. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$2,989.64** 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

[REDACTED]
[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
- Official Medical Fee Schedule
- Negotiated contracted rates: Contract Agreement
- Other: CCR § 5307.11, § 9789.50

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 additional remuneration 96367, 96368, 80053, 85027, 96411, 96413, 96416, and 99213-25 for date of service 05/01/2013.**
- Final EOR indicates reimbursement as per contractual obligation and “section 2” of contractual agreement and the statement, “Per this facility’s 2007 PPO amended contract, section #2 refers the provider back to the 2002 contract where #13 states "Nothing in this Agreement shall be construed as to require Payer to reimburse a greater amount or to cover more services than if this Agreement were not in effect".
- The Contract Agreement (copy) received for this review states the following under heading, **“Amendment to Participating Hospital Agreement”**:

This Amendment to Participating Hospital Agreement (“Amendment”) is entered into by and between Claims Administrator and Facility effective this August 1, 2007 to amend the agreement between the parties dated October 1, 1991 (“Agreement”)

1. Amendment of Fee Addendum. The Fee Addendum is hereby deleted in its entirety and replaced as follows: Applicable for Group Health, **Workers’ Compensation** and Other Payment Programs: A. Hospital Services All services shall be reimbursed at 90% of Provider’s billed charges.

As an Exempt Facility under the California Workers' Compensation Official Medical Fee Schedule, **all Workers' Compensation services shall be reimbursed under the rates/items listed above.**"

- Contractual Agreement **does not indicate** "eligible billed charges" or "eligible billed charges in accordance with a state mandated fee schedule." Contractual Agreement specifically indicates '90% of Provider's billed charges,' and acknowledges the Provider's "Exempt" status relating to the OMFS. **However, page 2, item 13** reflects the following contractual provision: **'Nothing in this Agreement shall be construed as to require Payer to reimburse a greater amount** or to cover more services than if this Agreement were not in effect, "indicating reimbursement subject to applicable sections of the OMFS for non-facility charges and the PPO Contract for facility related charges.
- **Exempt Facilities** under the OMFS are exempt from **Facility Only** reimbursement **but are not exempt** from reimbursement under various OMFS fee schedules such as DMEPOS, Laboratory, OMFS RBRVS, etc.
- **CCR § 5307.11:** 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.**
- **CCR § 9789.50 (a)** Pathology and Laboratory: Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California.
- **EOR's reflect 85027 and 80053** reimbursed accordingly pursuant to **CCR § 9789.50 (a)** Pathology and Laboratory Fee Schedule.
- **EOR's reflect CPT 96367, 96368, 96411, 96413 and 96416** reimbursed pursuant to **§ 9789.32. Applicability** (iii) The fees for any physician and non-physician practitioner professional services billed by the hospital shall be calculated in accordance with the OMFS RBRVS, using the OMFS RBRVS total **facility relative** value units.
 - **As an exempt facility under the OMFS**, "facility" fees do not apply and services are reimbursable under contractual provision of 90% of billed charges.
 - **Additional Reimbursement is Due Provider pursuant to CCR § 5307.11**

- Based on the aforementioned documentation and guidelines, additional reimbursement is due for 96367, 96368, 96411, 96413 and 96416

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 96367, 96368, 80053, 85027, 96411, 96413, 96416, and 99213-25

Date of Service: 05/01/2013					
HOPPS					
Service Codes	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
96367, 96368, 85027, 96411, 96413, 96416	\$1,401.00	\$532.39	\$3,557.28	\$3327.03	PPO (-) Reimbursed Amount = \$2,794.64 Due Provider Refer to Analysis

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

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