

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 6, 2016

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

IBR Case Number:	CB16-0000403	Date of Injury:	01/19/2011
Claim Number:	[REDACTED]	Application Received:	03/09/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/03/2015 – 11/03/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99283-25		

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 \$231.63 in additional reimbursement for a total of \$426.63. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$426.63** 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

[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 99283-25 services submitted for date of service 11/03/2015.**
- The Claims Administrator denied services indicating the following: “we cannot review without the necessary documentation, please resubmit with indicated documentation as soon as possible.”
- Opportunity to Dispute Eligibility Communicated with Provider on 03/10/2016; response not yet received.
- Contractual Agreement not submitted for IBR.
- Provider billed the disputed HCPCS code on a UB04, bill type 131 for date of service 11/03/2015.
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators."
- CCR § 9789.33, For services rendered on or after September 1, 2014, Status Indicators; “S”, “T”, “X”, or “V”, “Q1,” “Q2,” or “Q3” must qualify for separate payment.” must qualify for separate payment. APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- Medical record submitted included the H&P notes for the ER visit on 11/20/14. CPT guidelines requires all three components to be met for CPT **99283**: Expanded Problem Focused History; Expanded Problem Focused Examination; Medical decision making of Moderate Complexity.
- 99283 Status Indicator “V,” Wt: 2.2904
- Medical record demonstrated an Expanded Problem Focused History; Expanded Problem Focused Examination; Medical decision making of Moderate Complexity. CPT 99283 is recommended.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99283-25.**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99283-25

Date of Service: 11/03/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99283.25	\$1,268.00	\$0.00	\$231.63	1	\$231.63	Refer to Analysis

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]