

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 3, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-00001797	Date of Injury:	06/10/2004
Claim Number:	[REDACTED]	Application Received:	11/21/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/22/2014 - 5/22/2014		
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: 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 \$250.00 for the review cost and \$10.72 in additional reimbursement for a total of \$260.72. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$260.72 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
- Official Medical Fee Schedule

## 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 WC002 Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14(b)(1)), for date of service 05/22/2015.
- Claims Administrator denied the service with the following rationale: “This report does not fall under the guideline for a Separately Reimbursable Report found in the General Instructions Section of the Physician Fee Schedule. Last report paid PRT 05/08/2024: Under 30 days: Does not meet any of the guidelines listed in CCR 9785.”
- PR-2 for date of service 05/22/2014 indicates Injured Worker is being treated by the Provider for ongoing medical treatment relating to “depression and anxiety do to chronic pain,” and presented to the Provider “teary eyed” and in need of medical attention.
- There is no limit to the number of times a PR-2 report can be billed as long as the Injured Worker’s visit is medically necessary.
- The DWC Frequently Asked Questions section regarding PR-2 billing frequency states, “Within a 45-day period, the primary treating physician can bill for as many PR-2’s as are medically necessary. The purpose of the 45-day rule in California Code of Regulations, title 8, section 9785(f)(8) is to make sure that in the case of continuing treatment, that the patient’s progress is monitored *no less than* once every 45 days.
- Contractual Agreement Not Available for IBR.
- EOR Reflects 90% OMFS

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement is warranted for WC002.**

<b>Date of Service:</b> 05/22/2015							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
WC002	\$12.00	\$0.00	\$12.00	N/A	7	\$10.72	PPO contract

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]