

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 18, 2015

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001177	<b>Date of Injury:</b>	07/11/1988
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	12/01/2014
<b>Claims Administrator:</b>	[Redacted]		
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	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
- PPO Contract: 90% 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 Physician service W002 reports provided on 06/24/2014.
- **WC002** Claims Administrator denied reimbursement stating, “This report does not fall under the guidelines for a separately reimbursable report found in the general instructions section of the Physician’s Fee Schedule.”
- Progress Report indicates Injured Worker is “not progressing” and is currently undergoing treatment by the Provider who is the Inured Worker’s Primary Treating Physician.”
- DWC states, “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.” However, “Within a 45-day period, the primary treating physician can bill for as many PR-2’s as are medically necessary.”
- Progress Repot 06/24/2014 reflects the visit was medically necessary. As such, WC002 is a reimbursable report.
- Based on the aforementioned documentation and guidelines, reimbursement is warranted for WC002.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: WC002**

<b>Date of Service:</b> 06/24/2014							
<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	1	\$10.72	<b>PPO</b>

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