

**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 10, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0001880	Date of Injury:	09/17/2011
Claim Number:	[Redacted]	Application Received:	12/08/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/7/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	WC007		

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 \$110.08 in additional reimbursement for a total of \$360.00. If provider has been reimbursed for WC007 in the amount of \$110.08, then claims administrator is only responsible for the IBR application fee of \$250.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$360.00, unless payment has already been received by provider, 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

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
- Negotiated contracted rates:
- National Correct Coding Initiatives

## 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 is dissatisfied with denial of code WC007
- Claims administrator denied code indicating on the Explanation of Review “Requires the use of a modifier”
- Provider was requested by an attorney to provide a consult for the injured worker and give his opinion and recommendations for future care.
- The OMFS Physician Fee Regulations recommends the use of modifier -32 if a consultation is requested by the Workers’ Compensation Appeals Board, or the Administrative Director. Or modifier -30 if requested by a QME or AME. Provider was not requested by any of these but rather the attorney involved with this work comp case.
- WC007 is to be reimbursed \$38.68 for the first page and \$23.80 for each additional page with a maximum of six pages absent mutual agreement (\$157.68). Provider’s report submitted in this review was four pages totaling \$110.08 with no PPO agreement.
- Based on information reviewed, reimbursement for WC007 is warranted.
- Claims administrator submitted a written notice stating that they have sent payment to the provider. A copy of the payment was not received nor the EOR. If payment has not been received by provider from claims administrator for the WC007, then payment is still due. If payment has been received, then claims administrator is only responsible for the IBR application fee of \$250.00.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code WC007 is recommended.

<b>Date of Service: 5/13/2014</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
WC007	\$110.08	\$0.00	\$110.08	1	N/A	\$110.08	<b>DISPUTED SERVICE:</b> Allow reimbursement \$110.08

Copy to:

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