

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 3, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001344	Date of Injury:	06/21/2009
Claim Number:	[REDACTED]	Application Received:	08/13/2015
Assignment Date:	09/03/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/17/2014 – 10/17/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	WC007-30		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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

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 seeding remuneration for WC007 -30 Reports requested by AME/QME for date of service 10/17/2014.**
- The Claims Administrator denied service with the following rationale: “This report does not fall under the guidelines for a Separately Reimbursable Report.”
- OMFS **WC007 -30** definition: Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation. Use WC007, modifier -30.
- DWC QME & AME Definition: Qualified medical evaluators (QMEs) or agreed medical evaluators (AMEs) examine injured workers **to determine the benefits they will receive if there is a disagreement over the treating physician’s opinions.**
- Authorization dated “09/30/2014” indicates confirmation of the following authorized psychiatric service: “Psychiatric evaluation for **pre-op** clearance.”
- Authorization does not indicate referring Physician referred the Injured Worker to the Provider while working in the capacity as a QME or AME.
- Authorization indicates “certification for **medical necessity**” pursuant to “9792.6(b).” § **9792.6(b)** “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of **proposed medical treatment to cure or relieve the effects of the industrial injury** pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on the Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021, or on the “**Primary Treating Physician's**

Progress Report,” DWC Form PR-2, as contained in section 9785.2, or in narrative form containing the same information required in the DWC Form PR-2.

- A QME or AME referral is to prove or disprove a claim, Authorization indicates “pre-op clearance.”
- Documentation relating to Title 8, Article 5.6, Section 9795. Reasonable Level of Fees for Medical-Legal Expenses relating to QME & AME services and expenses not submitted for IBR.
- Additional information from the Referring Physician to the Provider to confirm QME/AME status not submitted for IBR.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for WC007-30.**

DETERMINATION OF ISSUE IN DISPUTE: WC007 - 30

Date of Service: 10/17/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
WC007-30	\$350.00	\$0.00	\$350.00	7	N/A	\$0.00	Refer to Analysis

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