

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 30, 2015

██████████  
██████████  
██████████

IBR Case Number:	CB15-0000638	Date of Injury:	8/22/2014
Claim Number:	██████████	Application Received:	4/24/2015
Claims Administrator:	██████████		
Date Assigned:	5/21/2015		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	99213 and WC002		

Dear ██████████

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 \$84.99 in additional reimbursement for a total of \$279.99. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$279.99 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: ██████████  
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## 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 codes 99213 and WC002
- Claims Administrator denied codes indicating on the Explanation of Review “Payment denied/reduced for absence of or exceeded pre-certification/authorization of treating doctor. If you require additional information regarding this bill decision, contact the claim handler”
- Pursuant §9792.5 Payment for Medical Treatment: (b) Any properly documented bill for medical treatment within the planned course, scope and duration of treatment reported under Section 9785 which is provided or authorized by the treating physician shall be paid by the claims administrator...
- An office visit does not require an authorization.
- Provider also billed code WC002 – Primary Treating Physician’s Progress Report.
- Per §9785 Reporting Duties of the Primary Treating Physician: (f)(7), reports required under this subdivision shall be submitted on the “Primary Treating Physician's Progress Report” form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled “Primary Treating Physician's Progress Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2.

