

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 8, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000756	Date of Injury:	10/20/2014
Claim Number:	[Redacted]	Application Received:	05/11/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	12/11/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29075-78RT and Q4010		

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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: §9785. Reporting Duties of the Primary Treating Physician

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 29075 and Q4010
- Claims Administrator denied codes indicating on the Explanation of Review “The charge was denied as the report documentation does not indicate that the service was performed”
- Provider billed code 29075 with modifier -78, unplanned return to the procedure room during the postoperative period. PR-2 submitted Provider states “pain with cast and pins per pt...discomfort, fever & chills. Taking Keflex, pain meds.”
- Under the PR-2 Treatment Plan, the report states ‘Include treatment rendered to date’. Report is documented “2. New short arm cast” and #3 is difficult to read as it is not clear and appears to state “cast later”. Documentation does not state a new cast was applied (29075) on date of service 12/18/2014. There is no description of materials used to justify billed code Q4010 as well. Documentation does not support billed codes.
- §9785. Reporting Duties of the Primary Treating Physician. (8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, **the report shall be signed** and transmitted within 20 days of the examination.
- Report submitted is unclear to be signed by the physician and therefore does not validate services were performed by the Provider.
- Reimbursement of codes 29075 and Q4010 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 29075 and Q4010

Date of Service: 12/11/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29075-78-RT	\$170.00	\$0.00	\$149.15	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
Q4010	\$40.00	\$0.00	\$19.04	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

Copy to:

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[REDACTED]

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