

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 31, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001088	Date of Injury:	10/17/2014
Claim Number:	[REDACTED]	Application Received:	07/06/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	07/24/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	20670-78 and 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 \$195.00 for the review cost and \$638.02 in additional reimbursement for a total of \$833.02. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$833.02** 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
- Official Medical Fee Schedule
- Treating Physician's Progress Report
- Global Days

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 20670-78 and WC002 Removal of implant; superficial and Treating Physician's Progress Report provided on January 15, 2015.**
- The Claims Administrator denied **20670-78** service with the following rational: "services unsubstantiated by documentation." The Claims Administrator also denied **WC002 service** with the following rational: "Secondary treatment physician report not payable".
- CPT code 20670-78, Removal of implant; superficial (leg, buried wire, pin or rod) (separate procedure). Modifier -78 appropriately appended (another procedure performed during the post-operative period of the initial procedure). Reimbursement is supported for 20670-78 as there was a submitted report for this service supporting this was a clearly distinct surgical procedure during the post operative period of the fracture report performed on 11/25/2014, which is not re-operation or treatment for complication. The global period does not apply.
- § 9789.12.14 Physicians and non-physician practitioners shall use the "California Specific Codes" listed below. Maximum reasonable fees for services performed by physicians and non-physician practitioners within their scope of practice shall be no more than the fee listed in section 9789.19, by date of service. The fees shall be updated annually in accordance with the Medicare Economic Index.
- Code WC002, Treating Physician's Progress Report. The physician that submitted the Treatment Physician's Report was the treating physician.
- Reimbursement for Reports, Duplicate Report, Chart Notes. The following treatment reports are separately reimbursable:
 - Primary Treating Physician's Progress Report

- Primary Treatment Physician’s Permanent and Stationary Report
- Psychiatric Report Requested by the WCAB or the Administrative Director, other than medical-legal report.
- The following treatment reports are not separately reimbursable as the appropriate fee is included within the underlying Evaluation and Management service, Physical Therapy Evaluation service or Occupation Therapy Evaluation service for an office visit:
 - Doctor’s First Report of Occupational Illness or Injury
 - Consultation Reports
 - Report by a secondary physician to the primary treating physician
 - Physician’s Return-to-work and Voucher Report
- Contractual Agreement Not Available for IBR.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 20670-78 and WC002

Date of Service: 01/15/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
20670-78	\$640.00	\$0.00	\$620.16	N/A	1	\$620.16	Refer to Analysis
WC002	\$11.92	\$0.00	\$11.92	N/A	1	\$11.92	Refer to Analysis

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