

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 7, 2016

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000421	Date of Injury:	07/01/2013
Claim Number:	[Redacted]	Application Received:	03/14/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	03/24/2014		
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 \$195.00 for the review cost and \$157.68 in additional reimbursement for a total of \$352.68. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$352.68** 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

[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
- OMFS

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 WC007-30 QME/AME Requested Consultation Reports, for date of service 03/24/2014.**
- The Claims Administrator denied service in full stating, “a charge was made or a separate procedure that does not meet the criteria for separate payment. See Physician’s Fee Schedule Gen.”
- Communication from Claims Administrator, dated March 12, 2014, to referring Provider reflects status as “Panel Qualified Medical Examiner,” requested by Claims Administrator to perform Med-Legal Evaluation and “this letter constitutes your authority to perform all tests which you believe are necessary.”
- **OMFS Physician Fee Regulations 1/1/2014: § 9789.12.12 Consultation Services Coding,** (b) Consultation reports are bundled into the underlying evaluation and management visit code, and are not separately payable, except as specified in subdivision (c).
 - (c) The following consultation reports are separately reimbursable: (1) Consultation reports requested by the Workers’ Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32. (2) **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**
- Submitted referral from AME (referring Provider) to Provider indicates the following stamped request:

- EMG/NCV and Neurodiagnostic testing and **Consultation Report** of Bilateral Upper Ext.
- WC007 - \$38.68 for first page \$23.80 each additional page. **Maximum of six pages absent mutual agreement (\$157.68)**
- **Based on the aforementioned, reimbursement is warranted for WC007-30.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: WC007-30

Date of Service: 03/24/2014						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
WC007	\$158.94	\$0.00	\$158.94	1	\$157.68	\$157.68 Due to Provider

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]