

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 8, 2016

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

IBR Case Number:	CB16-0000777	Date of Injury:	10/14/2014
Claim Number:	[REDACTED]	Application Received:	05/09/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/17/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99204 and 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: 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,  
MAXIMUS

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
- 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 99204 New Patient Evaluation Services and WC007-30 (Consultation Reports Requested by AME or QME), for date of service 03/17/2015.**
- The Claims Administrator's response to Dispute Eligibility received 5/24/2016 showing reimbursement for 99204 in the amount of \$181.59. Claims Administrator denied WC007-30 services in full due to "service is included within the value of another service performed on the same day."
- Submitted referral from QME (referring Provider) to Provider indicates the following request:
  - EMG/NCV and Neurodiagnostic testing and Consultation Report of Bilateral Upper Ext.
- **CCR § 9789.12.12 (c)(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**.
- CMS 1500 reflects 99204 and WC007; Modifier -30 appended to WC007.
  - EMG/NCV CPT codes not reflected
- Referring provider QME status verified via written request to QME from Legal Parties.
  - Written request to referring provider states "**Should you require any further diagnostic studies to complete your evaluation, I would ask that you please contact (representative) directly**"

- **QME authorized to perform tests or refer patient to another Provider was not identified in review.**
- Without an authorization to verify if the consultation report was approved, IBR is unable to determine if reimbursement of WC007-30 is warranted.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for WC007-30.**

The table on page 5 describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: WC007-30**

<b>Date of Service:</b> 03/17/2015						
<b>Provider</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
WC007-30	\$158.94	\$0.00	\$158.94	1	\$0.00	<b>Refer to Analysis</b>

Copy to:

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