

**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**

December 2, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB13-0000985	<b>Date of Injury:</b>	08/23/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	12/24/2013
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	07/29/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	99081		

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 \$335.00 for the review cost and \$22.22 in additional reimbursement for a total of \$357.22. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$357.22 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,

[Redacted]  
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: PPO Contract Discount 5%
- National Correct Coding Initiatives
- Other: OMFS Physician Services, Title 8 General Information and Instructions

## 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 CPT code 99081 for multiple injured workers on separate dates of service.
- Provider billed code 99081 – Primary Treating Physician’s Progress Report.
- Pursuant to Title 8 California Code of Regulations General Information and Instructions, Separately reimbursable reports identified by the CPT code 99081, (b) Separately Reimbursable Treatment Reports: Where an office visit is included, the report charge is payable in addition to the underlying Evaluation and Management service for an office visit (CPT codes 99201-99215): Primary Treating Physicians’ Progress Reports (PR-2), (1) the employee’s condition undergoes a **previously unexpected significant change**; (2) there is any **significant change in the treatment plan reported in the Doctor’s First Report**; (3) the employee’s condition permits return to modified or regular work, but the employee has not reached permanent and stationary status.
- If reimbursement is warranted, the Official Medical Fee Schedule has a maximum reimbursement of \$11.69 for CPT 99081.
- Injured worker #1 date of service 10/9/13, PR-2 states “Work Status: Return to work with restrictions as of 10/16/2013. Expected Maximum Medical Improvement (MMI) dated

11/15/2013. Work Restrictions: Restrictions for return to modified work as follows: frequent change of position as tolerated. Limited standing or walking. Limited overhead work. Limited stooping and bending. Limited lift, limited push and pull up to 20 lbs. Patient must wear back support.” PR-2 fulfills #3 of above for reimbursable reports and therefore reimbursement of 99081 is warranted for this injured worker’s case.

- Injured worker #2 date of service 10/02/2013 PR-2 states “Change in Treatment Plan.” Documentation mentions: Continue Physical Therapy; Cancel Acupuncture and prescribed Lodine. The report does not appear there was a significant change in the patient’s treatment or condition and therefore, reimbursement of 99081 is not warranted.
- Injured worker #3 date of service 09/24/2013 PR-2 states “Change in Treatment Plan”. Report mentions “Patient is currently on modified duty” then details exam on left shoulder and compares with non-injury right shoulder. Treatment Plan shows Physical Therapy ‘Pending’. Treatment Plan Comments does not mention any change in treatment plan for patient only refill of Nabumetone. Work Status shows restrictions, however, as stated at the beginning of the report “Patient is currently on modified duty.” Denial of code 99081 by the Claims Administrator was correct.
- Injured worker #4 date of service 09/13/2013 PR-2 states “Change in patient’s condition and Change in treatment plan.” Report documents “right foot and ankle decrease sensation” and “MRI of right foot and ankle ordered”. Claims Administrator denied code 99081 indicating on the Explanation of Review “Report by a secondary treating physician is not separately reimbursable per page 6 of the OMFS. Our records indicate [REDACTED] is the PTP.” No documentation was found for this review that bill submitted is the Primary Treating Physician and therefore reimbursement for code 99081 is not warranted.
- Injured worker #5 date of service 10/09/2013 PR-2 states “Change in patient’s condition and change in work status”. Report mentions “Patient is currently on modified duty” at the beginning of the report and then mentions back complaints/symptoms. Noting mentioned under Treatment Plan and under Comments only mentions “A 28 y/o male came in for Acute Thoracolumbar Contusion/Strain/Sprain. Feeling better. Start PT. Cont. meds. Still on light duty. MMI in 2-3 weeks. “Documentation does not support significant change in patient’s condition or any change in work status. The denial of the billed code 99081 by the Claims Administrator was correct.
- Injured worker #6 date of service 09/24/2013 PR-2 states “Change in patient’s condition” and “change in work status”. Beginning of the report states “Patient is currently on modified duty”. Treatment Plan shows Continue Physical Therapy. Treatment Plan Comments state “pt with l/s s/s, improving slowly. Continue with chiro and home PT. consider MRI if p fails chiro.” Documentation does not support unexpected significant change in patient’s condition or treatment and therefore does not warrant reimbursement.
- Injured worker #7 date of service 10/01/2013 PR-2 states “Change in treatment plan”. Report states “Patient is currently off work” mentioning “pt. was taken off duty unable to accommodate restrictions. Doing home exercise program and using supplies.” Under Work Status, provider documents “Return to work with restrictions as of 10/01/2013. Expected Maximum Medical Improvement (MMI) date 10/15/2013. Work Restrictions: limited stooping and bending. Limited lift, limited push and limited pull up to 25 lbs.” Based on the employee’s condition permits return to modified work, reimbursement of code 99081 is warranted.

- Injured worker #8 date of service 09/27/2013 Primary Treating Physician code 99081 was denied by Claims Administrator stating “The progress report and or Permanent and Stationary Report were disallowed as you are not the Primary Treating Physician or his/her designee. [REDACTED] appears to be PTP.” Provider did not submit anything documenting that he is the primary physician and therefore, Claims Administrator was correct in denying code 99081.
- Injured worker #9 date of service 09/17/2013 PR-2 states “Change in treatment plan” however; no significant change in treatment plan is documented only prescription dispensed. Based on information received, documentation submitted does not support reimbursement of 99081.
- PPO Contract reviewed shows a 5% discount to be applied.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of CPT code 99081 is outlined in the table below per case submitted.**

<b>Multiple Injured Workers for CPT 99081</b>						
<b>Physician Services</b>						
<b>Injured Worker</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>
Injured Worker #1: [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$11.69	<b>DISPUTED SERVICE:</b> Documentation reviewed supports allowance of reimbursement \$11.11
Injured worker #2 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement.
Injured worker #3 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement
Injured worker #4 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement.
Injured worker #5 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement.
Injured worker #6 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement.
Injured worker #7 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$11.69	<b>DISPUTED SERVICE:</b> Documentation reviewed supports allowance of reimbursement \$11.11

Injured worker #8 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement.
Injured worker #9 [REDACTED]	\$11.69	\$0.00	\$11.69	1	\$0.00	<b>DISPUTED SERVICE:</b> Documentation reviewed does not support allowance for reimbursement.

Copy to:

[REDACTED]  
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