
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 5, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001361	Date of Injury:	08/02/2011
Claim Number:	[REDACTED]	Application Received:	09/18/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/14/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99214,WC002 and 99070(NDC 54162054004)		

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 \$250.00 for the review cost and \$137.05 in additional reimbursement for a total of \$387.05. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$387.05 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:
- National Correct Coding Initiatives
- Other: OMFS Physician Services, Title 8 CCR §9785 Reporting Duties of the Primary Treating Physician, Labor Code 5307.1

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 billed codes 99214, WC002 and 99070 (NDC 54162054004)
- Claims Administrator denied billed codes and indicated on the Explanation of Review “Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.”
- Office visits between an injured worker and the Primary Treating Physician do not require an authorization. Therefore, Claims Administrator was incorrect to deny CPT 99214 and reimbursement is based on OMFS.
- Pursuant Title 8 §9785 Reporting Duties of the Primary Treating Physician: (f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs: (1) The employee's condition undergoes a previously unexpected significant change; (2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental

or purchase of durable medical equipment or orthotic devices; (3) The employee's condition permits return to modified or regular work; (4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications; (5) The employee is released from care; (6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury; (7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207. (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.

- Provider submitted a Primary Treating Physician's Progress Report (PR-2) which details the office visit on date of service 4/15/2014. The PR-2 documents a Detailed Exam and Medical Decision-Making of Moderate Complexity which qualifies the E/M visit as a 99214. PR-2 does not require an authorization. Reimbursement is warranted based on OMFS for this report as Provider states this is the Periodic Report (required 45 days after last report) and is required by Section §9785 of California Code of Regulations.
- Provider billed CPT code 99070 for NDC 54162054 Keratek Gel which he dispensed in his office documented on the PR-2 submitted. An authorization was submitted stating Kera-tek gel was approved by Claims Administration. Pursuant Labor Code 5307 .1(e) (2) Any compounded drug product shall be billed by the compounding pharmacy or dispensing physician at the ingredient level, with each ingredient identified using the applicable National Drug Code (NDC) of the ingredient and the corresponding quantity, and in accordance with regulations adopted by the California State Board of Pharmacy. Ingredients with no NDC shall not be separately reimbursable. The ingredient - level reimbursement shall be equal to 100 percent of the reimbursement allowed by the Medi-Cal payment system and payment shall be based on the sum of the allowable fee for each ingredient plus a dispensing fee equal to the dispensing fee allowed by the Medi-Cal payment systems. If the compounded drug product is dispensed by a physician, the maximum reimbursement shall not exceed 300 percent of documented paid costs, but in no case more than twenty dollars (\$20) above documented paid costs. (3) For a dangerous drug dispensed by a physician that is a finished drug product approved by the Federal Food and Drug Administration, the maximum reimbursement shall be according to the official medical fee schedule adopted by the administrative director. (4) For a dangerous device dispensed by a physician, the reimbursement to the physician shall not exceed either of the following: (A) the amount allowed for the device pursuant to the official medical fee schedule adopted by the administrative director. (B) One hundred twenty percent of the documented paid cost, but not less than 100 percent of the documented paid cost plus the minimum dispensing fee allowed for dispensing prescription drugs pursuant to the official medical fee schedule adopted by the administrative director, and not more than 100 percent of the documented paid cost plus two hundred fifty dollars (\$250). (5) For any pharmacy goods dispensed by a physician not subject to paragraph (2), (3), or (4), the maximum reimbursement to a physician for pharmacy goods

dispensed by the physician shall not exceed any of the following: (A) The amount allowed for the pharmacy goods pursuant to the official medical fee schedule adopted by the administrative director or pursuant to paragraph (2), as applicable. (B) One hundred twenty percent of the documented paid cost to the physician. (C) One hundred percent of the documented paid cost to the physician plus two hundred fifty dollars (\$250).

- Maximus requested proof of paid cost for NDC 54162054004 from the Provider. Provider stated “on this case, the pharmacy goods that was dispensed in doctor’s office *does not* require an invoice for reimbursement.” In order to determine maximum reimbursement for NDC 54162054004, dangerous drug, proof of paid cost is needed. Proof of paid cost was not received and therefore, reimbursement for NDC 54162054004 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of codes 99214 and WC002 are warranted.

Date of Service: 4/15/2014						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
99214	\$125.14	\$0.00	\$125.14	1	\$125.14	DISPUTED SERVICE: Allow reimbursement \$125.14
WC002	\$11.91	\$0.00	\$11.91	1	\$11.91	DISPUTED SERVICE: Allow reimbursement \$11.91
99070- NDC 54162054004	\$403.78	\$0.00	\$403.78	113	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

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