

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 19, 2014

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

IBR Case Number:	CB14-0001374	Date of Injury:	07/23/2012
Claim Number:	[REDACTED]	Application Received:	09/22/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/13/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99199 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 46103.6(f).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: [REDACTED]
Division of Workers’ Compensation (DWC) Medical Unit

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: California Specific Codes

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 codes 99199 and WC007
- Claims Administrator denied codes indicating on the Explanation of Review “This service appears to be unrelated to the patient’s diagnosis.”
- Provider submitted documentation which included a Request for Authorization for Medical Treatment. Procedure Requested: “Review records received one CD from AME Medical Group, Inc” Provider documented. Claims Administrator approved the request and noted “This is not something that needs approval as they were not requested by me”.
- Provider submitted a Primary Treating Physician’s Supplemental Report/Review of Medical Records along with a CMS 1500 form which billed codes 99199 and WC007.
- WC007 - Consultation Reports Requested by the Workers’ Compensation Appeals Board or the Administrative Director (Use modifier-32) Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b)(5)). (Use modifier - 30).
- Based on information reviewed, Claims Administrator was correct to deny codes as this was not a request from anyone other than the Primary Treating Physician. For Separately Reimbursable Reports, please see Title 8 California Code of Regulations under the Report section.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99199 and WC009 is not warranted.

Date of Service: 3/24/2014							
Physician Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99199	\$141.72	\$0.00	\$141.72	3	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
WC007	\$150.84	\$0.00	\$150.84	3	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

Copy to:

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Copy to:

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