

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 5, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000687	Date of Injury:	06/22/2012
Claim Number:	[REDACTED]	Application Received:	05/5/2014
Claims Administrator:	[REDACTED]	Assignment Date:	06/27/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99358 and 99080		

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 \$157.68 in additional reimbursement for a total of \$407.68. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$407.68 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,

[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:

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 99358, 99080 and 99080. Provider was requested to “review the records and issue a supplemental report addressing the patient’s prior injuries” on an injured worker requested by an attorney. Provider billed CPT 99358 and 99080. As of 1/1/2014 CPT 99358 and 99080 now have a Status Code ‘B’. B = Bundled Code. Payment for covered services are always bundled into payment of other services not specified. If RVUs are shown, they are not used for payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident.
- Based on review of the report submitted, Provider did review records and address patient’s prior injuries, as requested by the attorney. Therefore, Provider is due reimbursement for his services.
- Pursuant §9789.12.14, California Specific Codes: Effective 1/1/2014, Physicians and non-physician practitioners shall use the “California Specific Codes”(codes included are WC001-WC0012). Maximum reasonable fees for services performed by physicians and non-physician practitioners within their scope of practice shall be no more than the fee

listed in section 9789.19, by date of service. The fees shall be updated annually in accordance with the Medicare Economic Index.

- Based on information received in this review, Provider shall be reimbursed based on the California Specific Code WC007 – consultation reports requested by the Worker’s 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).
- WC007 is reimbursed as follows: \$38.68 for the first page and \$23.80 each additional page with a maximum of six pages.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code WC007 is warranted.

Date of Service: 2/12/2014						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Pages	Workers’ Comp Allowed Amt.	Notes
WC007	\$1470.00	\$0.00	\$1470.00	6 max	\$157.68	DISPUTED SERVICE: Allow reimbursement \$157.68

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