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

# Amended INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 26, 2015

[redacted]

| | | | |
|---|---|---|---|
| **IBR Case Number:** | CB14-0001425 | **Date of Injury:** | 07/31/2012 |
| **Claim Number:** | [redacted] | **Application Received:** | 09/26/2014 |
| **Claims Administrator:** | [redacted] | **Assignment Date:** | 11/04/2014 |
| **Provider Name:** | [redacted] | | |
| **Employee Name:** | [redacted] | | |
| **Disputed Codes:** | WC004 up to 15 pages | | |

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 $190.40 in additional reimbursement for a total of $$440.40. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of $440.40 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]

## 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

## 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 additional remuneration for WC004 PR4 report up to 15 pages. Upon second bill review, no additional payment for WC004 was issued.**
- Claims Administrator denied services with the following rational: "Reimbursement has been calculated according to fee schedule guidelines."
- WC004 PR-4 is reimbursed according to fee schedule at the rate of $38.68 for first page and $23.80 each additional page. Maximum of seven pages absent mutual agreement ($181.48).
- Signed authorization reflects a pre-determined CPT agreement to PR4 PTP report up to 15 pages.
- Payment for 99499 x 12 units of Record Review service provided for Injured Worker on 06/10/2014 was issued on 08/20/2014 by the Claims Administrator

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** WC004

| **Date of Service**: 06/10/2014 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | | |
| **Service Code** | **Provider Billed** | **Plan Allowed** | **Dispute Amount** | **Assist Surgeon** | **Units** | **Workers' Comp Allowed Amt.** | **Notes** |
| WC004 | $371.88 | $181.48 | $190.40 | N/A | 15 pages | $371.88 | $190.40 Due Provider Refer to Analysis |

Copy to:

[redacted]

Copy to:

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