

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 5, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001498	Date of Injury:	04/13/1998
Claim Number:	[Redacted]	Application Received:	10/06/2014
Claims Administrator:	[Redacted]	Assignment Date:	11/05/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99199, 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 4603.6(f).

Sincerely,

[Redacted]
[Redacted]

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

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 remuneration for 99199 Unlisted and WC007 services charged on 03/12/2014.
- The Claims Administrator denied WC007 services indicating the following: “This report does not fall under the guidelines of a separately reimbursable report,” and “The billed service requires use of a Modifier Code.”
- **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).
- Authorization, dated 02/13/2014, from Provider to Claims Administrator indicates “Physical Exam, X-rays, and Review of Records,” as requested service. No CPT Codes or Usual and Customary Fee referenced.
- Authorization, signed by Claims Administrator 02/18/2014 does not indicate service code fee for “Physical Exam, X-rays, and Review of Records,” and does not indicate a request for “Consultation Reports.”
- Documentation for Date of Service 03/12/2014 indicates the Provider is the “Primary Treating Physician.”
- Under title 8, CCR §9789.12.12 subdivision (c) the following consultation reports are separately reimbursable: 1) consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director, 2) consultation reports requested by the Qualified Medical Evaluator or Agreed Medical Evaluator. Other consultation reports are not separately payable; reimbursement is "bundled" into the evaluation and management code.

- **99199** service code reported as “Record Review” by the Primary Treating Physician. As with Consultation Reports, Record Review services are bundled into the Evaluation and Management Code.
- Documentation indicates the Provider performed an “initial evaluation” of the Injured Worker on February 20, 2014. The charged services, ‘Consultation Report’ and ‘Record Review’ would be bundled into the Evaluation and Service code for the February 20, 2014 date of service.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: DRG289

Date of Service: 03/12/2014							
Providers Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
99199	\$377.92	\$0.00	\$377.92	N/A	8	\$0.00	Refer to Analysis
WC007	\$351.96	\$0.00	\$351.96	N/A	7	\$0.00	Refer to Analysis

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