

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 3, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001674	Date of Injury:	01/01/2005
Claim Number:	[Redacted]	Application Received:	11/05/2014
Claims Administrator:	[Redacted]	Assignment Date:	12/10/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	WC004		

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 \$163.33 in additional reimbursement for a total of \$413.33. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$413.33 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,

Paul Manchester, M.D., M.P.H.
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

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 remuneration for WC004 Reports provided on 07/17/2014.**
- Claims Administrator reimbursement rationale: “This report does not fall under the guidelines of a separately reimbursable report.”
- **Reimbursement for Reports, Duplicate Reports, Chart Notes Title 8 §9789.14 (b) (3)** “Primary Treating Physician’s Permanent and Stationary Report (Form PR-4) issued in accordance with section 9785(h). Use Code WC004.”
- **Reporting Duties of the Primary Treating Physician §9785(h)** “When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall, unless good cause is shown, report within 20 days from the date of examination any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing and/or future medical care resulting from the injury. The information may be submitted on the “Primary Treating Physician's Permanent and Stationary Report” form (DWC Form PR-3 or DWC Form PR-4) contained in section 9785.3 or section 9785.4, or in such other manner which provides all the information required by Title 8, California Code of Regulations; section 10606. For permanent disability evaluation performed pursuant to the permanent disability evaluation schedule adopted on or after January 1, 2005, the primary treating physician's reports concerning the existence and extent of permanent impairment shall describe the

impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition (DWC Form PR-4). Qualified Medical Evaluators and Agreed Medical Evaluators may not use DWC Form PR-3 or DWC Form PR-4 to report medical-legal evaluations.”

- Documentation entitled “Permanent and Stationary,” report dated 07/17/2014, under the header “Permanent and Stationary Statement,” the Provider states, “It is my opinion that the patient has reached maximum medical improvement and the patient’s condition is permanent and stationary.” Under the header, “Future Medical Care,” the Provider states, “The patient should have access to future carpal tunnel release surgery, pain management, EMG and MRI of the shoulder and manipulation under anesthesia.”
- Agreement for WC004 reimbursement amount not availed for IBR.
- **§9789.14 9(a)** “WC004 - \$38.68 for first page \$23.80 each additional page. Maximum of seven pages absent mutual agreement (\$181.48).
- Contractual Agreement not available; 90% PPO reduction reflected on 08/15/2014 EOR.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement is warranted for WC004.

Date of Service: 07/17/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
WC004	\$265.00	\$0.00	\$265.00	N/A	1	\$163.33	PPO Contract

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