

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001908	Date of Injury:	04/23/2007
Claim Number:	[Redacted]	Application Received:	10/15/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	07/28/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204 and WC007-30		

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,

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 seeking full remuneration for 99204 New Patient Evaluation and WC007, Consultation Reports, for date of service 07/28/2014.**
- Claims Administrator denied the service with the following rationale: “Payment is denied as the service was provided outside the designated network” and “not authorized”
- **Article 5.3 Official Medical Fee Schedule §9789.12.12 (b) Consultation reports are bundled into the underlying evaluation and management visit code (c) (2) Consultation Services, separately reimbursable reports: Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation. Use WC007, Modifier -30**
- Original QME referral reviewed. QME Report and referral request written on a prescription form was verified requesting the following service from Provider:
 - EMG/NCV and Neurodiagnostic testing and consultation report of bilateral lower extremities.
- Communication from Legal Parties, dated February 21, 2014, confirms Referring Provider’s status as QME and authorized “medical and diagnostic tests”
- As only diagnostic testing was authorized, any report submitted is included in the RVUs for the testing and is not separately reimbursable.
- Provider did not bill for any diagnostic testing.
- Provider billed and Evaluation and Management 99204 and WC007 which were not authorized by Claims Administrator.

- Based on the aforementioned documentation and guidelines, reimbursement is not warranted for WC007 – 30 and 99204.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204 & WC007-30

Date of Service: 07/28/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99204 As 99203	\$354.10	\$0.00	\$354.10	N/A	1	\$0.00	Refer to Analysis
WC007-30	\$157.68	0.00	\$157.68	N/A	6	\$0.00	Refer to Analysis

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