

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 20, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001937	Date of Injury:	07/24/2012
Claim Number:	[Redacted]	Application Received:	10/19/2015
Assignment Date:	11/05/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	10/25/2014 – 10/25/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	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: 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 \$195.00 for the review cost and \$157.68 in additional reimbursement for a total of \$352.68. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$352.68** 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,

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

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 WC007-30 Consultation Reports Requested by AME or QME, for date of service 10/25/2015.**
- The Claims Administrator denied service in full.
- Communication from Claims Administrator, dated March 16, 2014, to **referring** Provider reflects status as “Agreed Medical Examiner,” requested by Claims Administrator to perform Med-Legal Evaluation with the authorization to “conduct such diagnostic test... necessary and appropriate...”
- Submitted referral from AME (referring Provider) to Provider indicates the following request:
 - EMG/NCV and Neurodiagnostic testing and Consultation Report of Bilateral Lower Ext.
 - EMG/NCV and Neurodiagnostic testing and Consultation Report of Bilateral Upper Ext.
- Although the referral from the AME is stamped “Consultation and Report,” **only the EMG/NCV testing**, in accordance with the AME acknowledgment letter, was **authorized** by the Claims Administrator. **However**, the Claims Administrator acknowledge acceptance of the Consultation service by virtue of reimbursement. With acceptance of the Consultation service, it follows that the WC007 is also an accepted service.
- WC007 - \$38.68 for first page, \$23.80 each additional page. Maximum of six pages absent mutual agreement (\$157.68)
- **Based on the aforementioned documentation and guidelines, reimbursement is not supported WC007-30 services.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204 and WC007-30

Date of Service: 10/25/2014							
In Patient Hospital							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
WC007-30	\$158.94	\$0.00	\$158.94	N/A	1	\$157.68	Refer to Analysis

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