

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 10, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0002109	Date of Injury:	06/12/2014
Claim Number:	[REDACTED]	Application Received:	11/18/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/18/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	WC002		

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, MD, MPH  
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
- Negotiated contracted rates: N/A
- National Correct Coding Initiatives

## 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 is seeking remuneration of WC002, Primary Treating Physician's Progress Report (PR-2), on date of service 08/18/2015.
- Claims Administrator denied billed code indicating "Report does not fall under the Fee schedule guidelines of a reimbursable report."
- Pursuant Title 8, CCR, § 9789.12.14 California Specific Codes- (1) Primary Treating Physician's Progress Report (Form PR-2), issued in accordance with **section 9785(f)**, using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785. Use Code WC002.
- §9785. Reporting Duties of the Primary Treating Physician:
- (f) A primary treating physician shall, unless good cause is shown, within 20 days report to the claims administrator when any one or more of the following occurs:
  - (1) The employee's condition undergoes a previously unexpected significant change;
  - (2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;
  - (3) The employee's condition permits return to modified or regular work;

- (4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;
- (5) The employee is released from care;
- (6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury;
- (7) The claims administrator reasonably requests appropriate additional information that is necessary to administer the claim. "Necessary" information is that which directly affects the provision of compensation benefits as defined in Labor Code Section 3207.
- (8) When continuing medical treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred. If an examination has occurred, the report shall be signed and transmitted within 20 days of the examination. Except for a response to a request for information made pursuant to subdivision (f)(7), reports required under this subdivision shall be submitted on the "Primary Treating Physician's Progress Report" form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled "Primary Treating Physician's Progress Report" in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2. A response to a request for information made pursuant to subdivision (f)(7) may be made in letter format. A narrative report and a letter format response to a request for information must contain the same declaration under penalty of perjury that is set forth in the Form PR-2: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code Â§ 139.3."
- Provider billed code along with CPT 99024, Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure.
- PR-2 submitted states that the injured worker is within the postoperative period following surgery on 08/06/2015.
- Report does not document any significant change in the patient's condition, no change in the treatment plan, is still off work, patient is not being released from care and has a future appointment with the provider, claims administrator did not request any information from the provider, and the visit was for a follow-up visit during the postoperative period not continued ongoing medical care.
- Based on guidelines and documentation reviewed, reimbursement of WC002 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code WC002

<b>Date of Service:</b> 08/18/2015					
<b>Physician Services</b>					
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
WC002	\$12.01	\$0.00	\$12.01	\$0.00	<b>Refer to Analysis</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]