

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 10, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0002118	Date of Injury:	10/12/2013
Claim Number:	[Redacted]	Application Received:	11/12/2015
Assignment Date:	12/07/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	05/27/2015 – 05/27/2015		
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: 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 \$11.91 in additional reimbursement for a total of \$206.91. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$206.91** 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
- OMFS

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 WC002 Primary Treating Physician Progress Report performed on 05/27/2015.**
- The Claims Administrator denied service stating: “Per the OMFS, a PR2 report is only reimbursable every 45 days unless there has been a significant change in the patients treatment/status.”
- The purpose of the 45-day rule in California Code of Regulations, Title 8, section 9785(f)(8) is to make sure that in the case of continuing treatment, that the patient’s progress is **monitored** no less than once every 45 days. However, Within a 45-day period, the primary treating physician can bill for as many PR-2’s as are medically necessary. (DWC Frequently Asked Questions)
- Unless otherwise dictated by Contractual Obligation, PR-2 reports are reimbursable when an Injured Worker is treated for continued medical care.
- Contractual Agreement not submitted for IBR.
- Opportunity to Dispute Eligibility communicated to the Claims Administrator on 11/19/2015; response not yet received.

- Submitted dictated PR-2 report, dated 6/4/2015 for date of service 05/27/2015, reflects the following:
 - **Intake:**
 - “**The patient complains of** constant low back pain. There is reduced range of motion. There is painful movement. He describes stabbing pains. The pain radiates down to the knees and ankles.”
 - “The patient returns to this office for further investigation of his orthopedic complaints.”
 - **Exam:**
 - C-Spine, R. Should, and L5-21 Bilaterally, “tenderness to palpation,”
 - **Treatment Plan:**
 - “The patient is to continue with his home exercise program for the lumbar spine including pelvic tilts, single and double knee to chest exercises, abdominal crunches, hamstring stretches, and lumbar extension exercises (lying prone and pushing up on hands/forearms/elbows), which helps improve flexibility, range of motion and strength.”
 - “The patient is to be considered Temporarily Totally Disabled until their next scheduled visit to this office (06/24/2015).”
- **Based on the aforementioned guidelines, reimbursement is recommended for California Specific Reporting Code WC002.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: WC002

Date of Service: 05/27/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
WC002	\$15.61	\$0.00	\$15.61	N/A	1	\$11.91	OMFS Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]