

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 30, 2015

[REDACTED]
[REDACTED]
[REDACTED]

| | | | |
|-----------------------|--------------|-----------------------|------------|
| IBR Case Number: | CB15-0001069 | Date of Injury: | 03/27/2013 |
| Claim Number: | [REDACTED] | Application Received: | 07/01/2015 |
| Claims Administrator: | [REDACTED] | | |
| Date(s) of service: | 02/17/2015 | | |
| 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 \$195.00 for the review cost and \$167.58 in additional reimbursement for a total of \$362.58. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$362.58 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, 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:
- 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 dissatisfied with reimbursement of WC004
- Claims Administrator reimbursed \$11.91 and changed code WC004 to a WC002 indicating “Based on available information” and “Reviewed as WC002”.
- §9785 Reporting Duties of the Primary Treating Physician: (8) "Permanent and stationary status" is the point when the employee has reached **maximal medical improvement**, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment. (g) 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.**
- §10606. Physicians' Reports as Evidence: (b) Medical reports should include where applicable: (1) the date of the examination; (2) the history of the injury; (3) the patient's complaints; (4) a listing of all information received in preparation of the report or relied upon for the formulation of the physician's opinion; (5) the patient's medical history,

including injuries and conditions, and residuals thereof, if any; (6) findings on examination; (7) a diagnosis; (8) opinion as to the nature, extent, and duration of disability and work limitations, if any; (9) cause of the disability; (10) treatment indicated, including past, continuing, and future medical care; (11) opinion as to whether or not permanent disability has resulted from the injury and whether or not it is stationary. If stationary, a description of the disability with a complete evaluation; (12) apportionment of disability, if any; (13) a determination of the percent of the total causation resulting from actual events of employment, if the injury is alleged to be a psychiatric injury; (14) the reasons for the opinion; and, (15) the signature of the physician.

- Page 11 of the Provider’s Report documents “...She does not require ongoing formal treatment at this time. Her final status is noted below. The patient has reached MAXIMAL MEDICAL IMPROVEMENT in accordance with the AMA Guides to the Evaluation of Permanent Impairment, (Fifth Edition).” Provider also documents Whole Person Impairment degrees for the patient’s injuries and all required criteria of Title 8, California Code of Regulations, section 10606.
- Based on information reviewed, additional reimbursement of WC004 is warranted.
- WC004 - \$38.25 for first page and \$23.54 each additional page. Maximum of seven pages absent mutual agreement (\$179.49)

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code WC004

| Date of Service: 02/17/2015 | | | | | | | |
|------------------------------------|------------------------|---------------------|-----------------------|--------------|-------------------------|-----------------------------------|---|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Multiple Surgery | Workers’ Comp Allowed Amt. | Notes |
| WC004 | \$178.20 | \$11.91 | \$166.29 | 7 | N/A | \$179.49 | DISPUTED SERVICE: Allow reimbursement \$167.58 |

Copy to:

[Redacted]

Copy to:

[Redacted]