INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 9, 2015

Dear [Name],

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 $250.00 for the review cost and $500.08 in additional reimbursement for a total of $750.08. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $750.08 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,

[Name]

cc: [Email]
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 denial of codes 99354 and 99355 plus unprocessed procedure 99245-25 by claims administrator.
- Claims administrator denied codes 99354 and 99355 indicating on the Explanation of Review “Procedure code should not be billed without appropriate primary procedure.”
- Provider billed codes 99245, 99354 and 99355 on a CMS 1500 form on the original billing and the SBR but claims administrator did not process code 99245 both times and denied 99354 and 99355.
- Documentation received included authorization from claims administrator stating “Enclosed please find authorization for a psychological consult for the above claim which is accepted for the low back and right hip. Please let this letter serve as continued authorization for psychological consult for the above claim which is accepted for the low back and right hip.”
- Provider’s report states “The psychological consultation required 3 hours of face-to-face clinical interview. 3 hours were required for non-face-to-face E&M review of records, diagnosis and disability and treatment assessments. Psychological test administration, scoring, and interpretation required 2 hours. An additional 2 hours were required for preparation and dictation of this report.”
- Based on information reviewed, reimbursement of 99245. 99354 and 99355 is warranted.
The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes 99245-25, 99355 and 99354 is recommended.

<table>
<thead>
<tr>
<th>Date of Service: 12/20/2013</th>
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<tr>
<td><strong>Physician Services</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Provider Billed</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Units</th>
<th>Multiple Surgery</th>
<th>Workers' Comp Allowed Amt.</th>
<th>Notes</th>
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<td>99245-25</td>
<td>$250.00</td>
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<td>$250.00</td>
<td>1</td>
<td>N/A</td>
<td>$238.79</td>
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<td>99355</td>
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<td>$100.00</td>
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<td>$90.10</td>
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<tr>
<td>99354</td>
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<td>$0.00</td>
<td>$200.00</td>
<td>N/A</td>
<td></td>
<td>$171.19</td>
<td><strong>DISPUTED SERVICE:</strong> Allow reimbursement $171.19</td>
</tr>
</tbody>
</table>

Copy to:

[Redacted]

Copy to:

[Redacted]