INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

Dear

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 $203.43 in additional reimbursement for a total of $453.43. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $453.43 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,

cc:
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: PPO Contract 10% Discount
• National Correct Coding Initiatives
• Other: OMFS Physician Fee Schedule

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 CPT 99205 and denial of CPTs 99354 and 99355.
• Claims Administrator reimbursed $172.00 and indicated on the Explanation of Review “The billing reflects procedure 99205. Based on the attached documentation, the history is comprehensive, the examination is comprehensive and the medical decision making appears to be of moderate complexity. In this instance, procedure 99204 appears more”
• Provider states: “99205 – The documentation provided for the specified date of service was in exact accordance with the 1997 documentation guidelines for evaluation and management service. 2 or more complexity factors were met for the E&M code billed. History met a high complexity, the examination met a moderate complexity, and the complexity of the medical decision making met a high complexity.”
• CPT 1997 shows CPT 99205 as “Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity”
• Based on review of the Doctors First Report Addendum, Claims Administrator was correct to down code 99205 to 99204 as documentation requires all three components to be filled.
• Provider does document his time spent with the patient as a total of 2 hours and 38 minutes on date of service 3/13/2014. CPT 99204 requires 45 minutes face to face time which leaves 113 minutes to be reimbursed. CPT 99354 is Prolong service first hour and 99355 is Prolong service each additional 30 minutes.
• Based on information received, Claims Administrator was incorrect to deny codes 99354 and 99355. Therefore, reimbursement of codes 99354 and 99355 is warranted.
• A PPO discount was applied to reimbursement on the Explanation or Review. Therefore, a 10% discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of codes 99354 and 99355 is recommended.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Provider Billed</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Assist Surgeon</th>
<th>Multiple Surgery</th>
<th>Workers’ Comp Allowed Amt.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205 (99204)</td>
<td>$237.67</td>
<td>$172.00</td>
<td>$65.67</td>
<td>N/A</td>
<td>N/A</td>
<td>$0.00</td>
<td>DISPUTED SERVICE: No reimbursement recommended</td>
</tr>
<tr>
<td>99354</td>
<td>$114.35</td>
<td>$0.00</td>
<td>$114.35</td>
<td>N/A</td>
<td>N/A</td>
<td>$102.92</td>
<td>DISPUTED SERVICE: Allow reimbursement $102.92</td>
</tr>
<tr>
<td>99355</td>
<td>$111.68</td>
<td>$0.00</td>
<td>$111.68</td>
<td>N/A</td>
<td>N/A</td>
<td>$100.51</td>
<td>DISPUTED SERVICE: Allow reimbursement $100.51</td>
</tr>
</tbody>
</table>

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