INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 17, 2014

Dear

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case, as assigned on 08/12/2014. 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 $1292.99 in additional reimbursement for a total of $1542.99. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1542.99 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]
Chief Coding Reviewer

cc: [Names]


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
- Other: OMFS Guidelines for Physician Billing

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 questioning reimbursement services performed on 11/25/2013 for CPT Service codes 99080, 96100, 99358, and 99354.
- **CPT code 99080 x 14 Units** - Special Reports or Forms: The Claims Administrator denied reimbursement for the following reason: “Required documentation missing; please resubmit.”
  - CPT 99080 is listed on the OMFS as “Special Reports” code and is a By Report code and is defined as, “Special reports such as insurance forms, more than the information conveyed in the usual medical communication or standard reporting form.”
    - Psychological testing was performed and the CPT Code includes “interpretation and report.”
- Based on the aforementioned documentation and guidelines, reimbursement is not warranted for CPT 99080.
- **CPT 96100 x 9 Units** - “Psychological testing with interpretation and report, per hour”: The Claims Administrator denied the service for the following reason: “Missing/incomplete support data for bill,”
Psychological Testing documentation specifies: “Diagnostic testing, scoring and interpretation: 9 hours.”

Based on the aforementioned documentation and guidelines, reimbursement is not warranted for CPT 96100 x 9 Units.

**CPT 99358 x 2 Units** – “Prolonged evaluation and management service before and/or after direct patient care; **first hour**: The Claims Administrator denied the service for the following reason: “Missing/incomplete support data for bill.”

Psychological Testing documentation specifies “Record Review: 0.5 hours.”

Documentation of the above referenced CPT code was not submitted. As such, prolonged evaluation and management services could not be verified.

Second bill review request from the Provider indicates “Time required Record Review: 0.5 hours (99358).”

Based on the aforementioned documentation and guidelines, reimbursement is not warranted for CPT 99358 x 2 Units as the documentation specifies less than one hour.

**CPT 99354** – “Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each 15 min.” : The Claims Administrator the charge for the following reason: “Missing/incomplete support data for bill”.

Second bill review request from the Provider states, “Time required for Clinical Interview with Patient: 2.0 hours (codes 99244; 99354).”

Documentation of the above referenced CPT code (99244) was not submitted. As such, prolonged services could not be verified.

Based on the aforementioned documentation and guidelines, reimbursement is not warranted for CPT 99354 x 2 Units.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE Based on the aforementioned guidelines and documentation:**

1) Reimbursement is warranted for CPT 96100 x 9 units.

2) Reimbursement is not warranted for CPT Codes 99080 – 59 x 14 units, 99358 x 2 units and 99354.

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<tr>
<th>Date of Service: 11/25/2013</th>
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<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>
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<td>$165.00</td>
<td>$0.00</td>
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</tr>
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<td>96100</td>
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<td>$900.00</td>
<td>9</td>
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<td>OMFS $99.91 x 9 Units x 85% Standard PPO (Reflected on EOR) = $746.31 Due Provider.</td>
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<td>Item Number</td>
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<td>Amount 2</td>
<td>Amount 3</td>
<td>Quantity</td>
<td>Unit</td>
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