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: UPHOLD.** MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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]
Medical Director

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:
  - National Correct Coding Initiatives
  - Other: Title 8 California Code of Regulations

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 code 99199
  Claims Administrator denied code indicating on the Explanation Of Review “This report is non-reimbursable under California Code of Regulations Section 9785 and the OMFS Labor Code 5307.1”
- CPT 99199, SPECIAL SERVICE/PROC/REPORT. Status Code ‘C’ - Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- Based on review of the report submitted, Provider states “This supplemental report is provided upon the request from the injured worker after she forwarded a copy of the qualified medical re-evaluation report dated March 5, 2014, for my review.”
- Pursuant Title 8 California Code of Regulations §9789.11 (a) (1), Treatment Reports: separate supplemental reports are not reimbursable. Separately reimbursable reports include: Primary Treating Physician’s Progress Reports, Final Treating Physician’s Report of Disability Status, Primary Treating Physicians’ Final Discharge Report and Primary Treating Physician’s Permanent and Stationary Report.
- Claims Administrator was correct to deny code 99199 for a Supplemental Report submitted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Based on information reviewed, reimbursement of code 99199 is not warranted.

<table>
<thead>
<tr>
<th>Date of Service: 4/17/2014</th>
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<tbody>
<tr>
<td><strong>Physician Services</strong></td>
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<tr>
<td>Service Code</td>
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<tr>
<td>99199</td>
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