

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 30, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB13-0000688	Date of Injury:	05/15/2011
Claim Number:	[Redacted]	Application Received:	11/5/2013
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99358 and 99080		

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.

IBR Case Assigned: 09/4/2014

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 an additional reimbursement of \$335.00 for the review cost and \$145.36 in additional reimbursement for a total of \$480.36. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$480.36 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,

[Redacted]
[Redacted]

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
- National Correct Coding Initiatives
- 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 dissatisfied with reimbursement of codes 99358 and 99080
- The Provider was reimbursed \$9.94 and is seeking additional reimbursement of \$481.22.
- Provider billed CPT code 99358 and was denied reimbursement as “No separate payment was made because the value of the service is included within the value of another service performed on the same day, (99354).” 99358 is described as - Prolonged Evaluation and Management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records, job analysis, evaluation of ergonomic status, work limitations, work capacity, or communication with other professionals and/or the patient family); each fifteen minutes.
- Medical documentation received states “Thirty-five minutes have been spent during face-to-face interview and examination of this patient. An additional one hour has been spent reviewing medical records submitted to my office in connection with this case. Likewise, forty-five minutes have been spent preparing this medicolegal report.”
- CPT code 99358 is described as “Where the physician is required to spend 15 or more minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in the communication with other professionals.” Provider has documented one hour of reviewing medical records. 99358, does not include time preparation for medicolegal reports.
- CPT code 99080 was also billed and reimbursed as “Based on the billing Primary treating physician’s progress report was submitted, therefore 99080 was changed to 99081.”
- When the physician determines that the employee’s condition is permanent and stationary, the physician shall report any findings concerning the existence and extent of permanent impairment and limitations and include, where appropriate, an assessment of apportionment, causation, and any need for continuing medical care resulting from the injury. The report shall be in accordance with Title 8, California Code of Regulations Section 9785. Use code 99080.

- Provider did not bill CPT 99080 with modifier 17; “Modifier ‘-17’ is to be used by the primary treating physician to identify a permanent and stationary evaluation and report. This modifier shall be appended to each of the following codes, as appropriate: Evaluation and Management codes, report code 99080, and prolonged service codes. Therefore, additional reimbursement is not recommended.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, additional reimbursement is warranted for CPT code 99358.

The table below describes the pertinent claim line information.

Date of Service: 03/27/2013						
[REDACTED]						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
99358	\$254.38	\$ 0.00	\$ 254.38	4	\$ 145.36	DISPUTED SERVICE: Additional Reimbursement \$145.36
99080	\$ 236.78	\$ 9.94	\$ 226.84	9 Pages	\$0.00	DISPUTED SERVICE: No Additional Reimbursement

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