

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 21, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000701	Date of Injury:	03/07/2013
Claim Number:	[REDACTED]	Application Received:	11/05/2013
Claims Administrator:	[REDACTED]	Assignment Date:	06/12/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99245, 99354, 99355, 99358 and 96100		

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.

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 \$335.00 for the review cost and \$309.90 in additional reimbursement for a total of \$644.90. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$644.90 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]
Chief Coding Reviewer

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
- Negotiated contracted rates: [REDACTED]
- National Correct Coding Initiatives
- Other: CMS 1997 Documentation Guidelines for Evaluation and Management Services, CPT published by AMA

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:** Consultation down coded from a 99245 to 99244, denial of CPT code 96100 (5 units), denial of CPT codes 99354 and 99355 (2 units).
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT were reviewed.
- CPT code 99245 is a Consultation based on typical time of 80 minutes face to face time with patient and or family. The use of code 99245 is substantiated based on the documentation of the examination. The physician attested that he spent 3 hours and 20 minutes fulfilling the requirements for a 99245. This is an additional 120 minutes over the typical time assigned by CPT. The prolonged office visit time fulfills code 99354 (60 minutes) and 2 units of 99355 (60 minutes). These codes are reimbursable.
- The medical record indicates “review of available medical records” documented as ten minutes. Code 99358 is not reimbursable per the OMFS which states: “service of less than 15 minutes is not reported separately.”

- Per the medical record documentation, the patient received 4.75 hours of psychological testing. This is reimbursed per hour. The physician received payment for 5 units of 96100 as per the Explanation of Review. The additional 5 units billed were appropriately denied.
- Per the [REDACTED] contract reimbursement is based on the lesser of 80% of billed charges, 95% of usual, customary and reasonable (UCR) or 95% of the OMFS.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement to be allowed for codes 99245, 99354 and 99355. Denial of 5 units 96100 and 99358 upheld. Claim Administrator to reimburse Provider additional amount of \$309.90.

Date of Service: 3/27/2013							
[REDACTED]							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99245	\$246.50	\$ 175.62 (based on 99244)	\$ 70.88	N/A	N/A	\$197.20 (% billed)	DISPUTED SERVICE: Allow reimbursement of E/M code 99245 at 80% of billed charges. Additional reimbursement of \$ 21.58 to be made.
99354	\$ 180.20	\$ 0	\$ 180.20	N/A	N/A	\$144.16 (% billed)	DISPUTED SERVICE: Allow reimbursement of 99354 at \$144.16 (80% of billed charges).
99355 (2 units)	\$ 180.20	\$ 0	\$ 180.20	N/A	N/A	\$144.16 (% billed)	DISPUTED SERVICE: Allow reimbursement of 99355 (2 units) = \$144.16.
96100 (5 units)	\$ 459.98	\$367.99	Unknown	N/A	N/A	\$367.99 (% billed)	DISPUTED SERVICE: Allow reimbursement at 80% of billed charges. No additional reimbursement warranted.
96100 (5 units)	\$ 328.89	\$0	Unknown	N/A	N/A	\$0	DISPUTED SERVICE: Units over initial 5 not substantiated. No additional reimbursement to be made.
99358	\$38.25	\$0	\$38.25	N/A	N/A	\$0	DISPUTED SERVICE: Deny service as code not substantiated.

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]