

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000061	Date of Injury:	08/22/2014
Claim Number:	[REDACTED]	Application Received:	01/16/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	2/11/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, 99354 and 99355		

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 \$195.00 for the review cost and \$226.03 in additional reimbursement for a total of \$421.03. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$421.03 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,

Paul Manchester, MD, MPH
Medical Director

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:
- National Correct Coding Initiatives

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 code 99205 and denial of codes 99345 and 99355
- Claims administrator down coded 99205 to a 99202 indicating on the Explanation of Review “The documentation doesn’t support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.”
- Provider billed code 99205: Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity.
- Based on review of the report submitted, the documentation did not substantiate the E&M code 99205. The evaluation and management services provided did not meet the three required components of CPT 99205: Comprehensive history and exam; and medical decision making of high complexity. Report submitted documents a straight forward medical decision making and therefore no further reimbursement is recommended for 99205.
- Provider does document in the report “Time spent with the patient today: 1 hour and 45 minutes”.
- 99354: Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office

