

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 24, 2015

██████████
████████████████████
████████████████████

IBR Case Number:	CB15-0001224	Date of Injury:	05/27/2014
Claim Number:	██████████	Application Received:	07/27/2015
Claims Administrator:	██████████		
Date(s) of service:	02/06/2015		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	99358 and 99080		

Dear ██████████

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 \$455.72 in additional reimbursement for a total of \$650.72. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$650.72 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: ██████████
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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

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 codes 99358 and 99080
- Claims Administrator denied codes indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- Documentation submitted includes the Provider’s Pre-Authorization and Pre-Negotiated Fee Arrangement which states “Pursuant to Labor Code Section 5307.11, provider and claims administrator agree to a one time agreement for payment of the following service(s) for the above named patient: Record Review 99358 \$36.34 per 15 minute increment; Written Report 99080 \$37.50 per page up to 6 max. By signing below, the authorized agent of the claims administrator pre-authorizes the above-noted services at the rates indicated”. Document is signed by the authorized agent of Claims Administrator and dated 9/8/14.
- Pursuant to LC § 5307.11 – “the medical fee schedule shall not apply to the contracted reimbursement rates.”
- California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:
- 5307.11. A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed

pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates. Except as provided in subdivision (b) of Section 5307.1, the official medical fee schedule shall establish maximum reimbursement rates for all medical services for injuries subject to this division provided by a health care provider or health care facility licensed pursuant to Section 1250 of the Health and Safety Code other than those specified in contracts subject to this section.

- Provider documents Record Review as 2 hours along with a nine page report.
- Based on the aforementioned guidelines, RFA dated 9/8/14 signifies the agreement of codes 99358 and 99080 between the two parties. Therefore, reimbursement of codes 99358 and 99080 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99358 and 99080

Date of Service: 02/06/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99358	\$350.00	\$0.00	\$350.00	8	\$290.72	DISPUTED SERVICE: Allow reimbursement \$290.72
99080	\$165.00	\$0.00	\$165.00	9	\$165.00	DISPUTED SERVICE: Allow reimbursement \$165.00

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