

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 5, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000319	Date of Injury:	05/18/2013
Claim Number:	[REDACTED]	Application	03/09/2015
Assignment Date:	04/06/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/06/2014 – 11/06/2014		
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.

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 \$515.00 in additional reimbursement for a total of \$710.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$710.00** 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, M.D., M.P.H.
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

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 seeking remuneration for Prolonged Non-Face-to-Face Services 99358 and 99080, Special Reports, performed on 11/26/2014.**
- Claims Administrator denied service with the following rationale: “No Separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- Provider seeking 2013 OMFS rates for 2014 service based on Prior Authorization.
- **CPT 99358 is considered part of the Evaluation and Management service** when performed on the same day. **However**, documentation authorizing for non-face-to face services, specifically authorizing 99358 was submitted for IBR.
- Page 1 of provided report indicates “**3.0**” hours of record review. Authorization specifies \$36.34 per 15 min increment.
- **CPT 99080** is not a valid code for 2014 date of service. However, documentation authorizing special reports, specifically 99080, was submitted for IBR indicating “\$27.50 per page up to 6 max.”
- **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.
- CPT 99358 and CPT 99080, although not separately reimbursable for 2014, defaults to the reimbursement contract terms acknowledged the Claims Administrator, as per **LC §5307.11 – “the medical fee schedule shall not apply to the contracted reimbursement rates.”**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99358 & 99080

Date of Service: 11/06/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99358	\$350.00	\$0.00	\$350.00	N/A	8	\$350.00	PPO Contract Refer to Analysis
99080	\$165.00	\$0.00	\$165.00	N/A	10	\$165.00	PPO Contract Refer to Analysis

Copy to:

[REDACTED]
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