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

# INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 6, 2015

[redacted]

| | | | |
|---|---|---|---|
| IBR Case Number: | CB15-0000633 | Date of Injury: | 3/29/2013 |
| Claim Number: | [redacted] | Application Received: | 4/23/2015 |
| Assignment Date: | 05/21/2015 | | |
| Claims Administrator: | [redacted] | | |
| Date(s) of service: | 1/12/2015 | | |
| Provider Name: | [redacted] | | |
| Employee Name: | [redacted] | | |
| Disputed Codes: | 99358 | | |

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 $72.68 in additional reimbursement for a total of $267.68. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **$267.68** 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]

## 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) for date of service on 01/12/2015.**
- Claims Administrator denied service with the following rational: "No Separate payment was made because the value of the service is included within the value of another service performed on the same day."
- **CPT 99358** is considered **part of the Evaluation and Management service** when performed on the same day. **However,** documentation of an authorization for non-face-to face services, specifically authorizing 99358 and 99359 was submitted for IBR.
- Authorization, signed "10/21/2014" by the Claims Administrator for a New Patient Office Visit and CPT Code 99358.
- Authorization includes the following information:
  - 99358/99499 Review of Records $148 per hour ($37.0-0 per 15 min = 1 unit)
- Although 99358 are considered part of an E&M service, the Authorization – reflecting only these services, was signed and acknowledged by the Claims Administrator as a requested service by the Provider thereby severing the bundled unit service into separately reimbursable units by mutual agreement.
- Evaluation and Management report documented the time relating to 99358.
- Signed attestation regarding the content of the E&M report, including CPT codes 99358, can be found on page 4 of the report.
- **Pursuant to LC § 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.
- The aforementioned 10/21/2014 documentation is contractual in nature. As such, the contractual rates apply pursuant to LC § 5307.11.
- EOR indicates PPO Fee Schedule 95% OMFS.

The table below describes the pertinent claim line information.

## DETERMINATION OF ISSUE IN DISPUTE: 99358

| **Date of Service**: 01/12/2015 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Physician Services** | | | | | | | |
| **Service Code** | **Provider Billed** | **Plan Allowed** | **Dispute Amount** | **Assist Surgeon** | **Units** | **Workers' Comp Allowed Amt.** | **Notes** |
| 99358 | $72.68 | $0.00 | $72.68 | N/A | 2 | $72.68 | **PPO Contract**<br>**Refer to Analysis** |

Copy to:

[redacted]

Copy to:

[redacted]