

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001119	Date of Injury:	08/26/2010
Claim Number:	[REDACTED]	Application Received:	07/13/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/19/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99358, 99359, 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 \$442.13 in additional reimbursement for a total of \$637.13. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$637.13 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: Contract Agreement and 5% PPO Discount
- 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, 99359, and reimbursement of 99355
- Claims Administrator denied code 99358 and 99359 indicating on the Explanation of Review “This code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the Provider’s jurisdiction”
- Request for Authorization dated 9/30/2014 requests CPT codes 99215, 99358/99359 and 95101. Bottom of RFA is signed by Claims Authorized Agent dated 10/8/14 with “Approved” box marked.
- § 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.
- Signed RFA by Claims Rep signifies a contract agreement between the two parties.

- Provider’s report documents “Record Review & Other Non-Face to Face Activities 1 Hours 45 Minutes”
- Based on information reviewed, reimbursement of codes 993658 and 99359 is warranted.
- Claims Administrator reimbursed \$109.52 for code 99355 indicating “Allowance was reduced as per contractual agreement”
- A copy of a PPO contract was not received for this review. However, EOR reflects a 5% Network Reduction was given to other codes reimbursed, except code 99355 which was reduced greater.
- Provider documents “Face to Face Time With Patient 2 Hours 50 Minutes”
- Based on discount given to CPT codes on EOR, additional reimbursement of 99355 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99358, 99359, and 99355

Date of Service: 11/19/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99355	\$418.83	\$109.52	\$225.52	3	N/A	\$318.29	DISPUTED SERVICE: Allow reimbursement \$208.77
99358	\$156.14	\$0.00	\$156.14	1	N/A	\$118.66	DISPUTED SERVICE: Allow reimbursement \$118.66
99359	\$150.92	\$0.00	\$150.92	2	N/A	\$114.70	DISPUTED SERVICE: Allow reimbursement \$114.70

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