

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 17, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001168	Date of Injury:	06/17/2014
Claim Number:	[REDACTED]	Application Received:	07/20/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/09/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, 99354, 72141-26, and WC002		

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 \$364.79 in additional reimbursement for a total of \$559.79. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$559.79 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 denial of codes 99205, 99354, 72141-26, and WC002
- Provider submitted a Spine Consultation Report/Request Authorization for New MRI, CT Scan and Flexion-Extension X-rays of the Cervical Spine.
- Provider documents “Thank you for your kind referral of the patient for surgical spine evaluation and consultation” and then documents a new patient Evaluation and Management visit submitting billed code 99205.
- Documentation supports billed code 99205 and therefore reimbursement is warranted.
- Provider billed code WC002 – Primary Treating Physician’s Progress Report, however, Provider is not the Primary Treating Physician.
- Reimbursement of WC002 is not warranted.
- Provider also billed code 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 or other outpatient Evaluation and Management service)
- Provider’s documentation does not indicate any amount of time spent with the injured worker to justify the prolonged service. Therefore, reimbursement of 99354 is not warranted.
- Provider also billed code 72141-26 - Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material

- Provider’s documentation states “MRI scan of the cervical spine dated 1/14/15. Actual images are reviewed by me. My findings are as follows:” and the report details the patient’s severe stenosis at C4-5 along with other findings.
- Based on information reviewed, reimbursement of 72141-26 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99205 and 72141-26

Date of Service: 06/09/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99205	\$379.08	\$0.00	\$252.72	1	N/A	\$252.72	<b>DISPUTED SERVICE:</b> Allow reimbursement \$252.72
72141-26	\$168.10	\$0.00	\$112.07	1	N/A	\$112.07	<b>DISPUTED SERVICE:</b> Allow reimbursement \$112.07

Copy to:

[REDACTED]  
 [REDACTED]  
 [REDACTED] [REDACTED]

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[REDACTED]  
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