

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 15, 2016

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

IBR Case Number:	CB16-0000491	Date of Injury:	06/25/2013
Claim Number:	[REDACTED]	Application Received:	03/23/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/18/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99358 and 99359		

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 \$306.18 in additional reimbursement for a total of \$501.18. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$501.18** 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

[REDACTED]  
[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 99358 Prolonged Evaluation and Management services before and/or after direct patient care; first hour and 99359 Prolonged Evaluation and Management services each additional 30 minutes, submitted for date of serviced 08/18/2015.**
- Claims Administrator denied 99358 and 99359 with the following rationale: “Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge.”
- **Authorization, signed 05/28/2015 by the Claims Administrator,** includes the following services as authorized:
  - 99205 Initial Evaluation
  - 99358 and 99359 – Record Review
  - 96101 Psych Testing
- Although 99358 and 99359 are considered part of an E&M service, the Authorization reflecting these services is signed and acknowledged by the Claims Administrator as a requested service by the Provider thereby severing the bundled unit services into separately reimbursable units by mutual agreement if the documentation supports the billed services.
- Document entitled “Psychiatric Evaluation,” under “Explanation of Charges,” documents the time relating to 99358 and 99359 as follows:
  - 1 Prolonged non face to face service-rec. review first hour. (99358)
  - 3 each additional 30 mins (99359)

- Authorization dated 05/28/2015 is contractual in nature; 99358 and 99359 time is clearly documented.
- EOR indicates PPO Fee Schedule 95% OMFS.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 99358 and 99359.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99358 & 99359**

<b>Date of Service:</b> 08/18/2015							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99358	\$156.14	\$0.00	\$156.14	N/A	1	\$125.38	\$125.38 Due to Provider
99359	\$226.38	\$0.00	\$226.38	N/A	3	\$180.80	\$180.80 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]