

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

May 19, 2016

██████████  
██████████  
██████████  
██████████

IBR Case Number:	CB16-0000697	Date of Injury:	01/23/2006
Claim Number:	██████████	Application Received:	04/26/2016
Claims Administrator:	██████████		
Date(s) of service:	12/15/2015		
Provider Name:	██████████████████		
Employee Name:	██████████		
Disputed Codes:	99358 x 6		

Dear ██████████:

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 \$145.36 in additional reimbursement for a total of \$340.36. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$340.36 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: ██████████  
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## 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 Rate
- 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 x 6 for date of service 12/15/2015.
- Claims Administrator's denial rationale as "bundled service"
- CPT 99358, prolonged evaluation and management service before and/or after direct patient care; first hour, is only billed once per date of service.
- Typically, 99358 for record review is a bundled service with the evaluation and management service billed on the same date of service.
- Documentation submitted by Provider states "The above physician has been chosen PTP for this injured worker. Pursuant to Labor Code 5307.11, provider and claims administrator agree to a one time agreement for payment of the following service(s) for the above named patient: Service: Record Review, Billing Code: 99358, Inches 1 inch, Total: \$1456.36" and is signed by authorized claims administrator and dated 11/17/15.
- **§ 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.**

- PR-2 submitted documents “Review of Medical Records”
- Opportunity for Claims Administrator to Dispute sent on 4/27/16. A response was not received for this review.
- Authorization dated 11/17/15 is contract in nature and therefore, reimbursement is warranted for 99358.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99358 x 6

<b>Date of Service:</b> 12/15/2015						
<b>Physician Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers’ Comp Allowed Amt.</b>	<b>Notes</b>
99358	\$1020.00	\$0.00	\$145.36	6	\$145.36	See Analysis

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