

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 22, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000017	<b>Date of Injury:</b>	06/11/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	01/07/2014
<b>Claims Administrator:</b>	[Redacted]		
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	99205 and 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.

IBR assignment date: 05/12/2014

**Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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,

[Redacted]  
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
- AMA CPT 1997

## 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 Physician service 99205 and 99358 services performed on 09/16/2013.
- Claims Administrator down-coded service to **99203** stating, “The billed services do not meet the criteria for a consultation” and “Charge adjusted to comply with the rate and rules of the contract indicated.”
- **All of the key components** of a New Patient service; History, Exam, & Medical Decision Making, must be met to determine the level of service. (1997 CPT E&M Guidelines).
- Abstracted information from Providers Report utilizing specialty specific A.A.O.S. Evaluation and Management Davidson Table revealed the following:
  - **History = Detailed** “an extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).”
  - **Exam = Comprehensive** “should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.”
  - **Medical Decision Making = Low**
- IBR documentation received does not meet the criteria for New Patient, Level 5.

- History = Comprehensive.
- Exam = Comprehensive, 30 systems general multi-system exam or complete exam of single organ system.
- Medical Decision Making = High Complexity.
- CPT 99358, Non face-to-face Prolonged Services denied by Claims Administrator stating, “The billed services do not meet the criteria for a consultation” and “Charge adjusted to comply with the rate and rules of the contract indicated.”
- 99358 is a time based code. Report provided does not indicate the total time spent on the exam or the total time spent “before and/or after direct (face-to-face) contact. (CPT 1997).
- Unable to verify 99358 services with documentation provided for IBR.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation, reimbursement is not warranted for 99205-93 and 99358 service.**

Date of Service: 09/16/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99205-93	\$205.40	\$102.83	\$102.57	N/A	1	\$102.83	<b>PPO Contract</b>
99358	\$109.02	\$0.00	\$109.02	N/A	1	\$0.00	<b>PPO Contract</b>

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