

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 20, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000746	<b>Date of Injury:</b>	05/15/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	05/14/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	07/03/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	99245 and 99080		

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 \$250.00 for the review cost and \$140.33 in additional reimbursement for a total of \$390.33. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$390.33 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,

[Redacted]  
Chief Coding Reviewer

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: none
- National Correct Coding Initiatives
- Other: CPT published by AMA

## 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:** CPT code 99245 was down coded to CPT code 99204. CPT code 99080 (6 units) was denied by the Claim Administrator.
- The Official Medical Fee Schedule and CPT were reviewed.
- Based on review of the medical record documentation the services provided are for a Consultation as per the Authorization notice from [REDACTED].
- Based on the Consultation Report, the documentation does not meet requirements for CPT code 99245. This level requires a Comprehensive History, Comprehensive Exam and High Decision Making. The level of service performed meets the guidelines for CPT code 99243. A Consultation reported with CPT code 99243 must meet all three key components. The History lacked a complete Review of Systems and the Examination did not support a Comprehensive examination based on the 1997 Coding Guidelines. The Musculoskeletal Examination requires every element to be documented (29 bullets) to satisfy a Comprehensive Musculoskeletal exam. The patient is returning to work and is improving and does not meet High complexity. Therefore reimbursement should be based on CPT code 99243.

- The reported CPT code 99080 is separately reimbursable (with a consultation) as stated in the Official Medical Fee Schedule, General Instructions, Page 6. Based on review of the case file this was not a doctor's first report or a secondary treating physician report but a consultation that was requested for transfer of care. Therefore the reports should be reimbursed.
- OMFS amount for 99080 = \$37.98 for 1<sup>st</sup> page and \$23.37 (pages 2-6).
- OMFS amount for 99243 = \$131.62.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimburse CPT code 99245 as CPT code 99243. Reimburse CPT code 99080 (6 units). Taking into account overpayment of line of service reported with CPT code 99245, the Provider is owed \$140.33.**

Date of Service: 10/25/2013							
[REDACTED]							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99245	\$425.00	\$146.12	\$278.88	N/A	N/A	\$131.62	<b>DISPUTED SERVICE:</b> Deny reimbursement of 99245 no additional reimbursement warranted.
99080 x6	\$ 162.95	\$ 0	\$ 162.95	N/A	N/A	\$ 154.83	<b>DISPUTED SERVICE:</b> Allow reimbursement for this service. Reimburse at \$154.83.

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
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