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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 10, 2015

[redacted]

IBR Case Number:	CB14-0001307	Date of Injury:	05/29/2009
Claim Number:	[redacted]	Application Received:	09/08/2014
Claims Administrator:	[redacted]		
Assigned Date:	12/23/2014		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99358 and 99081		

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 $79.31 in additional reimbursement for a total of $329.31. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $329.31 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]
Division of Workers' Compensation (DWC) Medical Unit

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: PPO Discount 6%
- 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 and 99081
- Claims administrator denied codes indicating on the Explanation of Review "Psyche is not an accepted industrial condition and has been determined to not be related to the industrial ankle injury"
- Report submitted states Permanent and Stationary for the injured worker with an industrial injury to the ankle that occurred on 5/29/2009. Provider documents a review of medical records which accounted for 1 hour and 55 minutes. CMS 1500 claim form shows provider billed 99215-17 showing this was a Permanent and Stationary exam along with 99358 and 99081.
- Date of service is 10/24/2013 which states 99358 was still a valid code to use for review of records without face to face contact for first hour. Information submitted shows provider billed for 1 hour and 55 minutes or 8 units. However, 99358 allows one hour or 4 units which is warranted for reimbursement.
- CPT 99081 is also a reimbursable code allowed for 1 unit.
- Based on information reviewed, reimbursement for codes 99358 and 99081 is warranted.
- PPO contract shows a 6% discount is to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99358 and 99081 is recommended.

Date of Service: 10/24/2013							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99358	$1200.00	$0.00	$290.72	4	N/A	$68.32	**DISPUTED SERVICE**: Allow reimbursement $68.32
99081	$50.00	$0.00	$11.69	1	N/A	$10.99	**DISPUTED SERVICE**: Allow reimbursement $10.99

Copy to:

[redacted]

Copy to:

Division of Workers' Compensation Medical Unit
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