

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 7, 2015

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001535	<b>Date of Injury:</b>	04/22/2014
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/14/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	11/10/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	99199		

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: 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
- Negotiated contracted rates:
- 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 code 99199.
- Claims Administrator denied CPT 99199 indicating on the Explanation of Review “Payment based on individual pre-negotiated agreement for this specific service.”
- CPT 99199, SPECIAL SERVICE/PROC/REPORT. Status Code ‘C’ - Carrier prices the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- Provider’s written appeal letter states: “Please note per the 2014 Relative Value Unit CPT code 99199 is a C status code, which is a ‘By Report code’ (attachment E) and also enclosed is our [REDACTED] Contract which indicates how by report procedure codes are to be processed (Attachment F). Our submitted medical/legal report falls within those guidelines. On 07/08/2014 additional medical records were received after the patient was already seen for their New Patient Evaluation. The provider spent 1.0 hours in review of the additional medical records.”
- Provider is stating they were submitting a “Medical-Legal” report. Medical-Legal reports have their own separate billing codes which would not fall under 99199.
- As of 01/01/2014, Record Review is not a separately payable procedure and is bundled into another service performed on the same dated of service.
- Claims Administrator was correct to deny code 99199 for a Record Review submitted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99199 is not warranted.**

Date of Service: 7/8/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99199	\$400.00	\$0.00	\$400.00	4	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended

Copy to:

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

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