

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 9, 2015

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001582	<b>Date of Injury:</b>	11/15/2012
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/21/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	11/12/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	WC007, 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 codes WC007 and 99199.
- Claims Administrator denied codes indicating on the Explanation of Review for code 99199 “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.” For code WC007 “No documentation to support service was requested/authorized by the WCAB, AD, QME, AME or claims administrator.”
- WC007 – Consultation reports requested by the Workers’ Compensation Appeals Board or the Administrative Director, QME or AME.
- Provider documents “These service were authorized by the claim adjuster. Fee schedule for this procedure is the usual and customary fee.”
- A Request for Authorization for Medical Treatment was received which states “Procedure Requested: Review records received two CDs from Esq.” The request was approved by claims administrator on 2/19/14. No specific request was made for a report and therefore, reimbursement for submitted report is not warranted.
- Claims administrator did reimburse provider in the amount of \$601.42 for review of records as 99199 was changed to 99358 and 99359. 99358 - Prolonged evaluation and

management service before and/or after direct patient care; first hour; 99359 - Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service).

According to report submitted, no direct patient contact was documented. Provider only documents “Review of said records and the applicant file required 5.5 hours with an additional 2.5 hours required to formulate my opinions and prepare this report.”

- As of 1/1/2014, medical record review is a bundled code in another service performed. Therefore, reimbursement of record review is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes Wc007 and 99199 is not recommended.

<b>Date of Service:</b> 3/8/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
WC007	\$955.32	\$0.00	\$955.32	19	N/A	\$0.00	<b>DISPUTED SERVICE:</b> Reimbursement not recommended.
99199	\$1511.68	\$601.42	\$910.26	32	N/A	\$0.00	<b>DISPUTED SERVICE:</b> Reimbursement not recommended

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