

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000059	Date of Injury:	08/29/2008
Claim Number:	[REDACTED]	Application Received:	01/16/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	2/11/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, WC003, 99358, 96101 and 96116		

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 \$195.00 for the review cost and \$237.67 in additional reimbursement for a total of \$432.67. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$432.67 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]
[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 99205, WC003, 99358, 96101 and 96116

- Claims administrator denied codes indicating on the Explanation of Review “Carrier not liable for claim/service/treatment”
- Documentation received included a letter from worker’s attorney stating that the worker has chosen this provider as the treating physician. A signed document with the worker’s signature stating she has chosen the attorney to represent her was also submitted.
- Based on the NCCI edits code pair exist between CPT 99205 and 96101 and 96116.
- Modifier Indicator column shows ‘1’ which states if a proper modifier is appended to the correct code and documentation supports the use of the procedure code then the edit may be overridden.
- A qualifying modifier was not appended to the column 2 codes: CPT 96101 or 96116. Reimbursement is not recommended for the billed codes 96101 or 96116.
- Billed code 99358, Prolonged evaluation and management service before and/or after direct patient care; first hour, was also billed. Effective 1/1/2014 99358 has a status ‘B’ in column D of the Medicare Physician Fee Schedule Relative Value File. Status code ‘B’ means: “Bundled Code. Payment for covered services are always bundled into payment for other services not specified.” Reimbursement of code 99358 is not warranted.
- WC003: Primary Treating Physician’s Permanent and Stationary Report

- The report submitted by the Provider was not identified as a Permanent and Stationary report, and did not meet the criteria of a separately reimbursable report.
- The Provider submitted an “Initial Psychological Evaluation Secondary Treating Physician’s Report Request for Authorization” report. This does not meet the criteria of a separately reimbursable report and the appropriate fee is included within the assessment and testing services performed the same day.
- Based on the report submitted, reimbursement of 99205 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99205 is recommended.

Date of Service: 8/28/2014							
Physician Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99205	\$315.00	\$0.00	\$315.00	1	N/A	\$237.67	DISPUTED SERVICE: Allow reimbursement \$237.67
WC003	\$220.00	\$0.00	\$220.00	23	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
99358	\$200.00	\$0.00	\$200.00	4	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
96101	\$1350.00	\$0.00	\$1350.00	22	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
96116	\$150.00	\$0.00	\$150.00	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.2	99205	96101	Allowed
Physician Version Number: 20.2	99205	96116	Allowed

Copy to:

██████████
 ██████████
 ██████████

██
 ██
 ██