

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 29, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000159	Date of Injury:	02/12/2014
Claim Number:	[Redacted]	Application Received:	02/02/2015
Claims Administrator:	[Redacted]		
Date Assigned:	2/26/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	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: 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,

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 WC003, 99358, 96101 & 96116
- Claims administrator denied code WC003 indicating on the Explanation of Review “The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the documentation submitted with the billing WC003”.
- Provider billed a WC003 – Primary Treating Physician’s Permanent and Stationary Report PR-3. Report submitted for this review states it is a Workers’ Compensation: Follow-Up Evaluation. Nowhere in this report is it mentioned any Permanent and Stationary condition for this injured worker. Provider was requested to perform a psychological evaluation on the injured worker not a request for Permanent and Stationary. Super bill submitted shows the procedure on date of service 10/10/2014 was an initial/comprehensive consultation. The report submitted by the provider is not from the primary treating physician and does not qualify for reimbursement. Therefore, reimbursement of WC003 is not warranted.
- Provider billed code 99358, Record Review. Effective 1/1/2014 Title 8 CCR §9789.12.8: CPT Code 99358 and CPT Code 99359 are both listed as status code "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 99358 is not warranted.

- Claims administrator denied codes 96101 and 96116 indicating on the Explanation of Review “Documentation of time spent performing these service(s) is needed for further review. Please submit time spent for each timed code. Please resubmit the requested information with the original billing.”
- No documentation of time spent, start and stop times, for these codes could be found in this review.
- Pursuant Title 8 CCR Physician Fee Schedule 1/1/2014, § 9789.12.13 Correct Coding Initiative: (a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
- Provider billed codes 96101 and 96116 along with 99205. Provider was reimbursed for procedure code 99205. Generally 96101 and 96116 are not billed with 99205, however, Modifier Indicator column shows ‘1’ which states if the correct code is appended with a qualifying modifier, and documentation is submitted to support the code billed, then the edit may be overridden. Provider did not append an appropriate modifier for codes 96101 and 96116.
- Based on Correct Coding Guidelines, reimbursement of codes 96101 and 96116 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes WC003, 99358, 96101 & 96116 is not recommended.

<b>Date of Service:</b> 10/10/2014							
<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>
WC003	\$220.00	\$0.00	\$220.00	23	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended
99358	\$50.00	\$0.00	\$50.00	1	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended
96101	\$1500.00	\$0.00	\$1500.00	8	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended
96116	\$300.00	\$0.00	\$300.00	2	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier Allowed</b>
Physician Version Number: 20.3	99205	96101	Yes
Physician Version Number: 20.3	99205	96116	Yes

Copy to:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]