

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 18, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001206	Date of Injury:	02/28/2014
Claim Number:	[REDACTED]	Application Received:	07/27/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/09/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99358 and 99359		

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 \$692.18 in additional reimbursement for a total of \$887.18. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$887.18 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
- 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 99359
- Claims Administrator denied codes indicating on the Explanation of Review “According to the Official Medical Fee Schedule, this service has a relative value of zero”
- Effective 1/1/2014 CPT codes 99358 and 99359 are bundled codes and payment is covered under other services.
- Documentation submitted includes the Provider’s Request for Authorization which states: “Service/Good Requested: Record Review; CPT/HCPCS Code: 99358/99359”... “Record review, by the agreement of the claims administrator, is a separately reimbursable, unbundled service”. Claims Administrator signed and dated (12/17/14) the RFA and checked the ‘Approved’ box.
- Pursuant to LC § 5307.11 – “the medical fee schedule shall not apply to the contracted reimbursement rates.”
- California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:
- 5307.11. A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee

schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates. Except as provided in subdivision (b) of Section 5307.1, the official medical fee schedule shall establish maximum reimbursement rates for all medical services for injuries subject to this division provided by a health care provider or health care facility licensed pursuant to Section 1250 of the Health and Safety Code other than those specified in contracts subject to this section.

- Provider documents Face to Face time with patient 4 hours 25 minutes and Record Review & Other Non-Face to Face Activities 5 hours and 45 minutes
- Based on the aforementioned guidelines, RFA dated 12/17/14 signifies the agreement of codes 99358 and 99359 between the two parties. Therefore, reimbursement of codes 99358 and 99359 is warranted.
- EOR received reflects 5% PPO discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99358 and 99359**

Date of Service: 02/09/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99358	\$156.14	\$0.00	\$156.14	1	\$118.66	<b>DISPUTED SERVICE:</b> Allow reimbursement \$118.66
99359	\$754.60	\$0.00	\$754.60	10	\$573.52	<b>DISPUTED SERVICE:</b> Allow reimbursement \$573.52

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