

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 19, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001207	Date of Injury:	08/14/2014
Claim Number:	[REDACTED]	Application Received:	07/27/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/29/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	95831, 99205, 99358, and WC007		

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 95831, 99205, 99358, and WC007
- Claims Administrator denied codes indicating on the Explanation of Review “Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or Provider”
- Authorization received dated 01/12/2015 for “Approved for evaluation and treatment with MPN + PM&R specialist within our network. A list of providers for you to choose from will be attached to this authorization”. Provider is listed on approved MPN list.
- Provider was requested for PMR evaluate and treat by the Requesting Physician.
- Provider’s report submit titled New Patient Consultation documents Evaluation and Management visit for date of service 1/29/15.
- Reimbursement of 99205-25 is warranted.
- Provider billed code 95831 - Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
- Report for muscle testing was not submitted for review. As documentation does not support billed code, reimbursement is not warranted for code 95831.
- Provider billed code 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour

- Effective 1/1/2014 - 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...." Title 8, CCR §9789.12.8
- Reimbursement of 99358 is not warranted.
- Provider billed code WC007 - Consultation Reports Requested by the Workers' Compensation Appeals Board or the Administrative Director (Use modifier -32), Consultation Reports requested by the QME or AME in the context of a medical-legal evaluation (Section 9789.14(b) (5)). (Use modifier -30)
- Provider was not requested to submit a report by the WCAB or AME/QME.
- Reimbursement of WC007 is not warranted.
- Based on information reviewed, reimbursement for 99205-25 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99205-25**

<b>Date of Service:</b> 01/29/2015						
<b>Physician Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99205	\$300.00	\$0.00	\$300.00	1	\$237.67	<b>DISPUTED SERVICE:</b> allow reimbursement \$237.67

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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[REDACTED]  
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[REDACTED]