

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 15, 2015

[Redacted]
[Redacted]
[Redacted]

| | | | |
|-----------------------|--------------|-----------------------|------------|
| IBR Case Number: | CB15-0000421 | Date of Injury: | 12/09/2010 |
| Claim Number: | [Redacted] | Application Received: | 03/23/2015 |
| Claims Administrator: | [Redacted] | | |
| Date Assigned: | 4/20/2015 | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 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: 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 \$1000.00 in additional reimbursement for a total of \$1195.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1195.00 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 code 99199, special service/procedure/report.
- Claims Administrator denied code indicating on the Explanation of Review “Charge for service is not covered under the Workers’ Compensation Program”
- Documentation submitted for review included a letter from Provider to Claims Administrator that his office had received medical records on above mentioned patient from the insurance carrier. Request for Authorization was states “Authorization for review of these records includes an agreement to pay for the review of records, and a supplemental report utilizing code 99199 or 99358 at a rate of \$62.50/unit, with each unit equal to 15 minutes of time”
- Provider requested that Claims Administrator acknowledges approval of request in writing. Claims Administrator signed the bottom of the RFA which states “Authorization is granted for review and supplemental report of the aforementioned medical records”
- Provider submitted his sixteen page report which documents a total of 4 hours for review of records and preparation of report.
- Based on information reviewed, reimbursement of 99199 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99199 is recommended.

| Date of Service: 11/5/2014 | | | | | | | |
|----------------------------|-----------------|--------------|----------------|-------|-------------------|----------------------------|---|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 99199 | \$1000.00 | \$0.00 | \$1000.00 | 16 | Percent reduction | \$1000.00 | DISPUTED SERVICE: Allow reimbursement of \$1000.00 |

Copy to:

[REDACTED]

Copy to:

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