

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 25, 2015

[Redacted]
[Redacted]
[Redacted]

| | | | |
|-----------------------|-----------------|-----------------------|------------|
| IBR Case Number: | CB15-0000559 | Date of Injury: | 12/01/2010 |
| Claim Number: | [Redacted] | Application Received: | 04/06/2015 |
| Claims Administrator: | [Redacted] | | |
| Date Assiged: | 5/14/2015 | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 99205 and 96101 | | |

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 reimbursement of 99205 and denial of 96101
- Claims Administrator denied code 96101 indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day (96101, 99354)
- Provider billed code 96101 along with CPT 99354 which was reimbursed.
- As a pair code exists between billed codes 96101 and 99354, these two code generally are not billed together. However, if an approved modifier were appended to the appropriate code, and documentation supports billed code then the edit may be overridden.
- Provider did not bill 96101 with a modifier and therefore was not billed correctly. Reimbursement of 96101 is not warranted.
- Provider is also dissatisfied with reimbursement of billed CPT code 99205 changed to 99215. Claims Administrator indicated on the Explanation of Review “The initial visit has been converted to an established visit since an initial visit has been previously billed”
- Provider’s request for a second review states “Our evaluation qualifies as a 99205 and not a 99215 because it required the following three components: (i)a comprehensive history; (ii)a comprehensive examination; and (iii)medical decision making of high complexity. The physician spent over 60 minutes face-to-face with the patient.”

- Claims Administrator does not deny the components were not met, only the established patient, not a new patient as 99205 mandates: 99205 - Office or other outpatient visit for the evaluation and management of a **new patient**.
- As provider does not deny the Claims Administrator's reason for the change in code as an established patient, nor does the Provider document in his report if the patient is a new patient, reimbursement of 99205 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99205 and 96101

| Date of Service: 9/16/2014 | | | | | | | |
|----------------------------|-----------------|--------------|----------------|-------|------------------|----------------------------|--|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 99205 | \$700.00 | \$167.15 | \$70.52 | 1 | N/A | \$167.15 | DISPUTED SERVICE: No reimbursement is recommended |
| 96101 | \$578.38 | \$0.00 | \$578.38 | 5 | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement is recommended |

National Correct Coding Initiative information:

| File | Column 1 | Column 2 | Modifier |
|--------------------------------|----------|----------|----------|
| Physician Version Number: 20.2 | 99354 | 96101 | Allowed |
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