

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 16, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000955	Date of Injury:	11/18/2013
Claim Number:	[REDACTED]	Application Received:	06/11/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/05/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99354, 99355, and 99358		

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 \$320.82 in additional reimbursement for a total of \$515.82. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$515.82 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: 5% PPO Discount
- 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 99354, 99355, and 99358
- Claims Administrator denied code 99358, Prolonged evaluation and management service before and/or after direct patient care; first hour, indicating on the Explanation of Review “Bundled in another procedure/ see state regulations”
- Provider’s RFA dated 11/26/14 requests “Record Review 99358/99359”
- Claims Administrator sent a Medical Services Authorization dated 11/26/14 stating “Although the medical treatment specified above has been approved, this letter does not constitute our agreement to pay for all charges for the authorized treatment as billed or to waive any objection regarding those charges. Your charges for authorized treatment will be subject to review and adjustment following our receipt of your bills for those services.”
- 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.
- Based on information reviewed, reimbursement of CPT 99358 is not warranted.

