

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 15, 2016

██████████
██████████████████
██████████

IBR Case Number:	CB15-0002296	Date of Injury:	09/29/2011
Claim Number:	██████████	Application Received:	12/21/2015
Assignment Date:	01/07/2016		
Claims Administrator:	██████████		
Date(s) of service:	09/03/2015 – 09/03/2015		
Provider Name:	██████████████████		
Employee Name:	██████████████████		
Disputed Codes:	99358 and 99080		

Dear ██████████

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 \$865.00 in additional reimbursement for a total of \$1,060.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$1,060.00** 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, M.D., M.P.H.
Medical Director

cc: ██████████
██

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

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 seeking remuneration for 99358 Prolonged Non-Face-to-Face Services and 99080 Special Reports for date of service on 09/03/2015.**
- Claims Administrator denied service with the following rationale: “No Separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- **CPT 99358** is considered **part of the Evaluation and Management service** when performed on the same day. **However**, documentation of an authorization for non-face-to-face services, specifically authorizing 99358 submitted for IBR.
- Authorization, signed 04/28/201 by the Claims Administrator indicates “agreement” for CPT Code 99358 for “record review.”
 - Authorization includes the following information:
 - 99358 \$36.34 per 15 min increments.
 - No indication of allowable units.
- Although 99358 are considered part of an E&M service, the Authorization – reflecting these services, was signed and acknowledged by the Claims Administrator as a requested service by the Provider thereby severing the bundled unit service into separately reimbursable units by mutual agreement.
- Neuropsychological Consultation Report, page 1, documented the time relating to 99358 as “6 hours.”
- CPT 99080, re-coded to WC001 First Report of Injury Report by the Claims Administrator.
- Authorization, signed 04/28/201 by the Claims Administrator indicates “agreement” for CPT Code 99080 for “written reports.”
 - Authorization includes the following information:
 - 99080 \$37.50 per page up to 6 max
 - No indication of allowable units
- Neuropsychological Consultation Report is 23 pages in length.
- **Pursuant to LC § 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.
- Opportunity to Dispute communicated to Claims Administrator on 12/22/2015; response not yet received.
- **The aforementioned 04/28/2015 authorization is contractual in nature, as such, the contractual rates apply pursuant to LC § 5307.11.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99358 and 99080

Date of Service: 09/03/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99358	\$700.00	\$0.00	\$700.00	N/A	32	\$700.00	PPO Contract Refer to Analysis
99080	\$165.00	\$0.00	\$165.00	N/A	23	\$165.00	PPO Contract Refer to Analysis

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