

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 25, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0002302	Date of Injury:	08/11/2014
Claim Number:	[Redacted]	Application Received:	12/21/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	07/07/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99223 and 99356		

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 \$244.53 in additional reimbursement for a total of \$439.53. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$439.53 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
- 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 seeking remuneration for codes 99223 and 99356 performed on 07/07/2015
- Provider billed codes 99223 and 99356 on a CMS 1500 form with Place of Service '21'.
- 99223 – Initial hospital care/day 70 minutes
- 99356 - Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
- Claims Administrator denied codes indicating “Charges are unrelated to industrial injury”
- Authorization submitted for review documents: “Determination: 1.Recommend retrospective request for 1 For reconsideration: Retrospective review for in-hospital Acute Pain Consultation related to lumbar spine injury between 7/7/2015 and 7/11/2015 be certified” dated September 11, 2015.
- Provider’s Consultation report documents consultation for “patient’s acute postoperative lumbar spine pain after L4-L5 lumbar spine fusion surgery with instrumentation.” The report further documents: “I spent over 60 minutes in consultation with an additional 30 minutes of medical record review”
- Provider documents a total of 90 minutes of consultation time with the patient. 70 minutes of the total 90 minutes account for 99223. 99356 is a time based code which requires at least 30 minutes and documented time allowed an extra 20 minutes after consultation of 70 minutes. Reimbursement of 99356 is not warranted.

- Based on aforementioned documentation and guidelines, reimbursement of 99223 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99223 and 99356

Date of Service: 07/07/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99223	\$1200.00	\$0.00	\$244.53	1	\$244.53	\$244.53 Due to Provider
99356	\$300.00	\$0.00	\$111.14	4	\$0.00	Refer to Analysis

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