

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 26, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0002002	Date of Injury:	07/30/2014
Claim Number:	[REDACTED]	Application Received:	12/31/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/28/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, 99354, 99355, 96101-59		

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 \$250.00 for the review cost and \$272.59 in additional reimbursement for a total of \$522.59. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$522.59 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 reimbursement of codes 99205, 96101 and denial of codes 99354 and 99355.
- Claims administrator reimbursed \$453.30 for code 96101 indicating on the Explanation of Review “Workers’ Compensation state fee schedule adjustment”.
- Provider billed code 96101 x 4.8 units which is rounded up to 5 units as this code is per hour. OMFS shows 96101 allowable  $\$90.66 \times 5 = 453.30$ . Provider was reimbursed 100% of OMFS and therefore no further reimbursement is warranted.
- Billed code 99205 was down coded to 99204 indicating on the Explanation of Review “Based on the available information, the services rendered appear to best be described by this code/labor code 5307.1”.
- 99205 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity.
- Report submitted documents all three components required for a 99205 and therefore, additional reimbursement is warranted for code 99205.
- Provider documents on the report a total of 2 hours and 30 minutes spent face to face with the patient. 99205 is considered the first 60 minutes, 99354 is an additional hour with 99355 each additional 30 minutes all of which were submitted on the CMA 1500

form by the provider. Codes 99354 and 99355 were denied by claims administrator for lack of documentation.

- Based on information reviewed, reimbursement of codes 99354 and 99355 are warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 9/10/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99205	\$297.09	\$191.11	\$105.98	1	N/A	\$237.67	<b>DISPUTED SERVICE:</b> Allow reimbursement \$46.56
96101-59	\$583.30	\$453.30	\$130.00	5	N/A	\$453.30	<b>DISPUTED SERVICE:</b> No reimbursement recommended
99354	\$142.94	\$0.00	\$142.94	1	N/A	\$114.35	<b>DISPUTED SERVICE:</b> Allow reimbursement \$114.35
99355	\$139.61	\$0.00	\$139.61	1	N/A	\$111.68	<b>DISPUTED SERVICE:</b> Allow reimbursement \$111.68

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