

**MAXIMUS FEDERAL SERVICES, INC.**

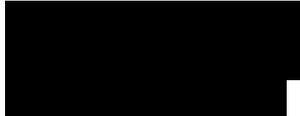
Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 3, 2016



IBR Case Number:	CB16-0000040	Date of Injury:	07/19/2015
Claim Number:	[REDACTED]	Application Received:	01/08/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	09/09/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	96101-59 and 99354		

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, M.D., M.P.H.  
Medical Director

Cc: [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
- Medicare MLN Matters
- NCCI Edits
- OMFS

## 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 additional remuneration for 99354 Prolonged Services with Direct Face-to-Face contact and 96101-59 Psychological testing submitted for date of service 09/09/2015.**
- The Claims Administrator denied 96101 reimbursement 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.”
- Utilization Review letter dated 08/17/2015 documents services requested and certified as “Psytx, office, 20-30 min 90804, Quantity: 1 (psych consult AOE/COE)” Psychological testing does not appear to have been requested nor certified. Therefore, reimbursement of 96101 is not warranted.
- Claims Administrator denied 99354 indicating “We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible”
- **MLN Matters Document MM5972** - Prolonged Services with Direct Face-to-Face Patient Contact Service - Documentation is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. **The start and end times of the visit shall be documented in the medical record** along with the date of service.

- Documentation reflecting the Providers direct contact with Injured Worker totaled 1 ½ hours, and the start and end times were not indicated on the document.
- **Based on the documentation submitted, reimbursement for 99354 and 96101-59 services is not indicated.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99354 & 96101-59**

<b>Date of Service:</b> 09/09/2015						
Physician Services						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99354	\$150.00	\$0.00	\$150.00	1	\$0.00	<b>Refer to Analysis</b>
96101	\$300.00	\$0.00	\$300.00	3	\$0.00	<b>Refer to Analysis</b>

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