
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 13, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000487	Date of Injury:	05/06/2010
Claim Number:	[REDACTED]	Application Received:	03/22/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/20/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	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: 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 \$120.98 in additional reimbursement for a total of \$315.98. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$315.98** 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

[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
- 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 remuneration for 99354 Prolonged Services with Direct Face-to-Face Contact performed on **10/20/2015**.
- The Claims Administrator denied services based on documentation.
- **CPT 99354 Definition:** Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; **first hour** (list separately in addition to code for office or other outpatient evaluation and management service).
- **CMS 1500 indicates** a series of services performed including a New Patient Evaluation.
- **EOR** indicates reimbursement for 99213, Office Evaluation.
- CPT 99213 is a **Parent Code** to add-on CPT 99354.
- **CPT 99213:** Office or other outpatient visit for the evaluation and management of an established patient, typically, **15 minutes are spent face-to-face** with the patient and/or family.
- **Primary Treating Physician's Progress Report**, Page 1, Provider indicates "**Time spent with patient 52 minutes**".
- Pursuant **MLN Matters Number MM5972:** You can only bill the prolonged services codes if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) **equals or exceeds the threshold time** for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).
- **CMS Manual System, Pub 100-04 Medicare Claims Processing:** Threshold Time to Bill Code 99354 billed with Office/Outpatient and Consultation Code 99213 is 45 minutes.

- Opportunity for Claims Administrator to Dispute sent on 3/23/2016. A response from Claims Administrator was not received for this review.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99354.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99354

Date of Service: 10/20/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99354	\$120.98	\$0.00	\$120.98	1	\$120.98	Refer to Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]