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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 19, 2014

[redacted]

IBR Case Number:	CB14-0000819	**Date of Injury:**	10/23/2008
Claim Number:	[redacted]	**Application Received:**	6/5/2014
Claims Administrator:	[redacted]	**Assignment Date:**	7/15/2014
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 Claims Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $114.35 in additional reimbursement for a total of $364.35. A detailed explanation of the decision is provided later in this letter.

The Claims Administrator is required to reimburse the Provider a total of $364.35 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,

[redacted]
Chief Coding Reviewer

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
- Official Medical Fee Schedule
- Negotiated contracted rates: none included
- Other: CMS MLN Matters MM5972

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**: CPT code 99354 was denied by Claim Administrator.
- The Official Medical Fee Schedule and CPT 2014 Edition were reviewed.
- Based on review of the medical record documentation the services provided support the use of CPT code 99354.
- The PR-2 documentation for date of service 3/13/14 includes documentation to support a Moderate Decision Making, 99214, plus the additional time that exceeds the typical time spent for a 99214 office visit of 25 minutes. "Time spent with patient 58 minutes" was included on the PR-2. Per the MLN Matters bulletin, MM5972, the definition of a Prolonged Service: "*In the office or other outpatient setting, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code.* " The MLM Matters also clarifies the Prolonged Service code must have a required companion code: "*The companion E&M codes for 99354 are: Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215).*" As per the CMS regulation, the office code, 99214, falls within the required companion code. The entire visit was not counseling so therefore would be based on medical decision making which was Moderate, 99214, for this visit. The visit exceeds 33 minutes which falls within the code parameters for CPT code 99354.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimburse CPT code 99354.

Date of Service: 3/13/2014							
Physician/Practitioner/Assistant Surgeon.							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99354	$114.35	$0	$114.35	N/A	N/A	$114.35	**DISPUTED SERVICE**: Allow reimbursement for 99354 at $114.35.

Copy to:

[redacted]

Copy to:

[redacted]