

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 1, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001525	Date of Injury:	01/02/2014
Claim Number:	[REDACTED]	Application Received:	09/02/2015
Assignment Date:	09/21/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/15/2105 – 01/15/2105		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99354 and 99355		

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]  
[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 & 99355 Prolonged Services with Direct Face-to-Face Contact performed on 01/15/2015.**
- The Claims Administrator denied services based on documentation.
- §9789.12.13. Correct Coding Initiative.(a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
- **Primary Treating Physician’s “Final Report” reviewed.** Under the heading “Certification,” the Provider indicates “2 hours and 5 minutes” spent with Patient. Additional information reflects the following in evidence of time spent: “Review of report for structural content performed as well as dictation/ review of history, physical.”
- Although the total time spent is 2.5 hours, the supporting documentation also indicates that “dictation” was included in the overall time.
- The start and end time of the actual fact-to-face time could not be abstracted from the documentation or subtracted from the time spent for ‘dictation.’
- **MLN Matters Document MM597** - 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.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 99354 and 99355.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99354 & 99355**

<b>Date of Service:</b> 01/15/2015 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 & 99355	\$226.03	\$0.00	\$226.03	1	\$0.00	<b>Refer to Analysis</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]