

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 7, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001529	Date of Injury:	06/01/2012
Claim Number:	[REDACTED]	Application Received:	09/03/2015
Assignment Date:	09/21/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/10/2014 – 12/10/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99354 and WC007		

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, 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

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, and WC007 performed on 12/10/2015.**
- The Claims Administrator denied 99354 as “Included in the value of another service performed on the same day.”
- **Psychological Report Reviewed for time component.** Page 13 of the report indicates “2.0” hours face to face time with patient. However, the start and end time of the actual fact-to-face time could not be abstracted from the documentation or subtracted from the overall time spent on the Psychological Testing (including report prep) also performed on the same day.
- **CMS 1500** indicates a New Patient Evaluation and Management Parent code to 99354.
- **CCR § 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.

- **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.
- Without the required time elements for 99354, additional reimbursement to billed New Patient Evaluation Parent Code is not indicated.
- **WC007** reimbursement denied by the Claims Administrator as “not requested by QME or AME.”
- **CMS 1500 indicates WC007 – 30** Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation.
- **04/21/2014 Authorization** for Psychological Consultation and specifically, “**WC007 - 32,**” indicates “Approved” by the Claims Administrator.
- **WC007-32 Modifier:** Consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director.
- **The submitted modifier** reflected on the CMS 1500 is “**30,**” which is **not** the authorized modifier, modifier **-32.**
- **Article 5.5.0.** Rules For Medical Treatment Billing and Payment § 9792.5.7. Requesting Independent Bill Review (b)(2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicted for 99354 or WC007-30.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 96101, 99354 & WC007

Date of Service: 08/29/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
96101	\$893.86	\$715.08	\$893.86	8.5	N/A	\$715.08	Refer to Analysis
99354	\$350.00	\$0.00	\$350.00	1	N/A	\$0.00	Refer to Analysis
WC007	\$350.00	\$0.00	\$350.00	7	N/A	\$0.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
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