

**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 21, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001700	Date of Injury:	04/14/1989
Claim Number:	[Redacted]	Application Received:	09/22/2015
Assignment Date:	10/13/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	02/19/2015 – 02/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99354, 99355, 99358, and 99359		

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 \$185.28 in additional reimbursement for a total of \$380.28. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$380.28** 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

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 AND 99358 & 99359 Prolonged Services without Direct Face-o-Face Contact, performed on 02/19/2015.**
- 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 “Face to Face Time,” the Provider indicates “3 hours and 45 minutes.” Additional time elements reflected in documentation relate to record review and physiological testing.
- Although the total time spent for Face-to-Face time indicates ‘3 hours and 45 minutes,’ the start and end time of the actual fact-to-face time could not be abstracted from the documentation.
- **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.
- **Authorization for 99358 & 99359 Prolonged Services, without Face-to-Face Contact faxed by Claims Administrator to Provider on 02/13/2015.**
  - Authorization does not specify max number of units for 99359.
- **CCR § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates **different from those in the fee schedule**, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code **shall not apply to the contracted reimbursement rates.**
- Although 99358 and 99359 are status “B” indicators and are typically bundled into Evaluation and Management Services, the aforementioned 02/13/2015 Authorization is contractual in nature and contractual obligations apply pursuant to **CCR § 5307.11.**

- Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 99354 and 99355 and is supported for 99358 and 99359.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99354, 99355, 99358 & 99359**

<b>Date of Service:</b> 02/19/2015						
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	\$840.99	\$0.00	\$840.99	1	\$0.00	<b>Refer to Analysis</b>
99358 & 99359	\$231.60	\$0.00	\$231.60	1	\$185.28	<b>Refer to Analysis</b>

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