

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2015

[Redacted]

IBR Case Number:	CB15-0002041	Date of Injury:	06/17/2014
Claim Number:	[Redacted]	Application Received:	11/04/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/24/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99354, WC007, and 96101		

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 \$793.28 in additional reimbursement for a total of \$988.28. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$988.28** 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]

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 Prolonged Services with Face-to-Face Contact, 99354 (parent code), WC007-30 Consultation reports requested by the Qualified Medical Evaluator (“QME”) and 96101 Psychological Testing performed on 03/24/2015.
- Claims Administrator denied service with the following rationale:
 - 99354: “Prolonged Evaluation and Management services not identified”
- **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.
- Psychology Report indicates total time spent on tasks. Actual start and end relating to 99354 is not indicated. Without a start and end time, the actual time spent on specific code 99354 cannot be determined. As such, reimbursement is upheld.
- Referral by QME submitted includes the following information request:
 - Psychological Evaluation & TX- Initial
- Referral does not include a request for a report. Therefore, WC007 is included in the Evaluation and Management service and a separately reimbursement is not warranted.
- 96101 was denied by Claims Administrator with rationale “included/bundled”

- Claims Administrator is not stating Psychological Testing was not authorized.
- Provider submitted a separate Psychological Testing Report which documents a total of “8.75 hours (units)” for application, scoring and interpretation along with the report.
- Based on information reviewed, reimbursement of 96101-59 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99354, WC007, and 96101

Date of Service: 03/24/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99354	\$350.00	\$0.00	\$350.00	N/A	1	\$0.00	Refer to Analysis
WC007	\$550.00	\$0.00	\$550.00	N/A	1	\$0.00	Refer to Analysis
96101	\$920.15	\$0.00	\$920.15	N/A	8.75	\$793.28	\$793.28 Due to Provider

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