

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 2, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0002050	Date of Injury:	08/05/2014
Claim Number:	[REDACTED]	Application Received:	11/06/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/23/2015		
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, 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
- 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 and Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation, WC007-30 performed on **02/23/2015**.
- Claims Administrator denied service with the following rationale:
  - 99354: “We cannot review this service without a copy of the necessary documentation. Please resubmit with indicated documentation as soon as possible.”
  - WC007-30: “The charge for the procedure exceeds the amount indicated in the fee schedule”
- **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.
- Provider’s 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 does not request a report from Provider.

- Authorization to QME dated January 07, 2015 shows “Psyche Consultation” medically necessary.
- A request for a consultation report was not approved by Utilization Review.
- Based on information reviewed, reimbursement of WC007-30 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99354 & WC007**

<b>Date of Service:</b> 02/23/2015							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers’ Comp Allowed Amt.</b>	<b>Notes</b>
99354	\$350.00	\$0.00	\$350.00	N/A	1	\$0.00	<b>Refer to Analysis</b>
WC007	\$550.00	\$0.00	\$550.00	N/A	1	\$0.00	<b>Refer to Analysis</b>

Copy to:

[REDACTED]  
 [REDACTED]  
 [REDACTED]

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[REDACTED]  
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