

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 16, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

|                       |                 |                       |            |
|-----------------------|-----------------|-----------------------|------------|
| IBR Case Number:      | CB15-0002165    | Date of Injury:       | 02/24/2006 |
| Claim Number:         | [REDACTED]      | Application Received: | 11/23/2015 |
| Claims Administrator: | [REDACTED]      |                       |            |
| Date(s) of service:   | 04/28/2015      |                       |            |
| 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: 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 \$238.21 in additional reimbursement for a total of \$433.21. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$433.21** 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 performed on 04/28/2015.**
- The Claims Administrator denied services based on documentation.
- **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.
- **CPT 99354 Definition:** Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; **first hour** (list separately in addition to code for office or other outpatient evaluation and management service).
- **CPT 99355 Definition:** Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; **each additional 30 minutes** (list separately in addition to code for prolonged service)
- **CMS 1500 indicates** a series of services performed include ding a New Patient Evaluation.
- **EOR** indicates reimbursement for 99203, New Patient Evaluation.
- CPT 99203 is a **Parent Code** to add-on CPT 99354.

- CPT 99355 is an add-on code to 99354.
- Consideration of time for add-on services begins when the time involved with the **Parent Code** ends.
- **CPT 99203 Definition:** Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, **30 minutes are spent face-to-face with the patient** and/or family.
- **Primary Treating Physician's "First Report of Injury,** Provider indicates **"2 hours and 39 minutes"** of face-to-face time with the Injured Worker.
- 99203 @ 30 minutes + 99354 @ 60 min = 1.5 hours + 99354 @ .50 min = 2 hours.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99354 and 99355.**

The table below describes the pertinent claim line information.

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

| Date of Service: 04/28/2015<br>Physician Services |                 |              |                |       |                            |                   |
|---|-----------------|--------------|----------------|-------|----------------------------|-------------------|
| Service Code                                      | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes             |
| 99354 & 99355                                     | \$238.55        | \$0.00       | \$238.55       | 1     | \$238.21                   | Refer to Analysis |

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