

**MAXIMUS FEDERAL SERVICES, INC.**

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



---

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 4, 2016

[REDACTED]

IBR Case Number:	CB16-0000041	Date of Injury:	11/03/2014
Claim Number:	[REDACTED]	Application Received:	01/08/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	09/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205-25, 99354, and 95922		

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 \$112.65 in additional reimbursement for a total of \$307.65. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$307.65 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  
Medicare MLN Matters  
NCCI Edits  
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 additional remuneration for 99205-25, 99354, and 95922 submitted for date of service 09/23/2015.**

- Communication dated 9/9/2015 from Claims Administrator to Provider states “Consult and treatment is authorized”.
- Claims Administrator denied 99354 indicating “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- **MLN Matters Document MM5972** - 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.
- Documentation reflecting the Providers direct contact with Injured Worker totaled 1 ½ hours with ½ hour for Capnometer testing, and the start and end times were not indicated on the document.
- **Based on the documentation submitted, reimbursement for 99354 service is not indicated.**
- Claims Administrator also denied 95922 with rationale “charge denied as the report/documentation does not indicate that the service was performed”

95922: Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least 5 minutes of passive tilt

- Code 95922 should be reported only when all of the following components are included in testing:
  1. **Continuous recording of beat-to-beat BP and heart rate. The heart rate needs to be derived from an electrocardiogram (ECG) unit such that an accurate quantitative graphical measurement of the R-R interval is obtained**
  2. **A period of supine rest of at least 20 minutes prior to testing.**
  3. **The performance and recording of beat-to-beat blood pressure and heart rate during a minimum of two (2) Valsalva maneuvers.**
  4. **The performance of passive head-up tilt with continuous recording of beat-to-beat blood pressure and heart rate for a minimum of five minutes, followed by passive tilt-back to the supine position. This must be performed using a tilt table.**
- Provider's Consultation Report submitted documents Capnometer testing to include Results and Interpretation along with submitted Capnometer Graphs. Report does not document all necessary components for 95922 and therefore, reimbursement is not warranted for 95922.
- CPT 99205 was changed to 90791 by Claims Administrator with rationale "documentation does not support the level of service billed"
- § 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.
- Communication to Provider from Claims Administrator on 9/9/2015 authorizing "Consult" is contract in nature. Reimbursement of 99205 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99205**

<b>Date of Service:</b> 09/23/2015 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>
99205	\$275.00	\$140.08	\$150.00	1	\$252.73	<b>\$112.65 Due to Provider</b>

Copy to:

