

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 26, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000173	Date of Injury:	10/30/2012
Claim Number:	[REDACTED]	Application Received:	02/05/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/01/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99355, 99358, 99359, and 96101-59		

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 \$728.61 in additional reimbursement for a total of \$923.61. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$923.61** 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
- 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 99355 (add-on), and Prolonged Services without Face-to-Face Contact 99358 (parent code) and 99359 (add-on) and Psychological testing per hour 96101-59 performed on **04/01/2014**.
- Claims Administrator denied service with the following rational:
 - 99355: “Payer deems the information submitted does not support this level of service.”
 - 99358 & 99359: “This is a bundled code, there is no RVU or payment amount for this service.”
 - 96101: “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”
- **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 99355 is not indicated. Without a start and end time, the actual time spent on specific code 99355 cannot be determined. As such, reimbursement is upheld.

- **CPT 99358 and 99359** are considered **part of the Evaluation and Management service** when performed on the same day. **However**, documentation of an authorization for non-face-to face services, specifically authorizing 99358 and 99359 was submitted for IBR.
- Authorization, signed “1/07/2014” by the Claims Administrator for CPT Codes 99358 & 99359.
 - Signed Authorization includes the following information:
 - Record Review 99358 and 99359
 - “This service not to be bundled with other services by agreement of claims administrator reimbursable at RBRVS,” listed under “Other Information”
- Although 99358 and 99359 are considered part of an E&M service, the Authorization reflecting these services, was signed and acknowledged by the Claims Administrator as a requested service by the Provider thereby severing the bundled unit service into separately reimbursable units by mutual agreement.
- Evaluation and Management report documented the time relating to 99358 and 99359 Non-Face-to-Face services.
- Psychological diagnostic testing submitted as 96101-59 for a total of 4.75 hours submitted by Provider.
- Authorization dated 1/07/2014 does not include service 96101.
- Reimbursement of 96101 is upheld.
- E&M Report indicates **1 unit** for first hour of parent code 99358 and **10 units** for 99359. A total of 5 hours and 50 minutes documented by Provider.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 96101-59, 99355, 99358 & 99359

Date of Service: 04/01/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
96101	\$142.94	\$0.00	\$142.94	N/A	1	\$0.00	OMFS
99355	\$698.05	\$0.00	\$698.05	N/A	1	\$0.00	OMFS
99358	\$156.14	\$0.00	\$156.14	N/A	1	\$124.91	OMFS
99359	\$150.92	\$0.00	\$150.92	N/A	10	\$603.70	OMFS

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

Copy to:

[REDACTED]

[REDACTED]