INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 14, 2014

Dear [Name],

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 $335.00 for the review cost and $484.28 in additional reimbursement for a total of $819.28. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $819.28 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,

[Name]

Chief Coding Reviewer

cc:
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
- Contractual Agreement
- AMA CPT 1997

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 disputing reimbursement for 99215, 99080-17, 99358-17 and 99358 services performed on 10/22/2013.
- CPT 99215 Code Description: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
  - A comprehensive history;
  - A comprehensive examination;
  - Medical decision making of high 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 to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
- Claims Administrator down coded CPT 99215 to 99214 for the following reason: “Recommend 99214 due to detailed history and detailed exam.”
- The Provider submitted a “Primary Treating Physician’s Final Report.” Abstracted information revealed the following:
  - Required elements of Permanent and Stationary Reporting as per §10606. “Physicians' Reports as Evidence.”
  - An Expanded Problem Focused History
  - A comprehensive examination; for example Provider performed several range of motion measurements.
Medical decision making of high complexity as Causation and Apportionment was determined for “Permanent and Stationary Status” utilizing AMA Guidelines as stipulated by

- Level of Evaluation and Management service abstracted date revealed an Established Patient Level 5 in accordance with the 1995/1997 Evaluation and Management guidelines authorized under OMFS.
- OMFS: “To bill for the primary treating physician’s permanent and stationary report, the physician shall select the appropriate Evaluation and Management code, if any, in accordance with Evaluation and Management guideline 9 g; the report code 99080; and, when appropriate, prolonged service codes 99354-99358.”
- CPT code 99080 x 15 Units - Special Reports or Forms: The Claims Administrator reimbursement rational, “Paid at rate and rules of contract indicated.”
- OMFS as “Special Reports” code and is a By Report code and is defined as, “Special reports such as insurance forms, more than the information conveyed in the usual medical communication or standard reporting form, reimbursable up to 6 pages.”
- CPT 99800 -17 x 15 units was reimbursed accordingly under PPO and OMFS guidelines.
- CPT 99358 -17, x 9 units - Prolonged Services, Without Face-to-Face, each 15min: The Claims Administrator denied services citing, “Prolonged E/M services not justified/documented.”
- Primary Treating Physician’s Final Report, page 15 certifies “2 hours and 15 minutes” for prolonged services.
- CPT 99354-17 – Prolonged Services direct Face-to-Face contact, each 30 min: The Claims administrator denied the service for the following reason: “Prolonged E/M services not justified/documented.”
- Provided report states Provider spent, “1 hour and 24 min with patient.” CPT Code 99215 is time factor is “40 min,” = 1 billable unit for 99354.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement of codes 99215, 99080-17 x 18 Units, 99358-17 x9 Units, & 99354-17 is warranted.

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<th>Date of Service: 10/23/2013</th>
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