

MAXIMUS FEDERAL SERVICES, INC.

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

12/10/2013

Independent Bill Review Final Determination Reversed

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 5/31/2013 – 5/31/2013
MAXIMUS IBR Case: CB13-0000377

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/11/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$39.04, for a total of \$374.04.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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 or negotiated contract: PPO Contract
- Other: OMFS Evaluation and Management Guidelines

Supporting Analysis:

The dispute regards the amount paid for Evaluation and Management services (99215) on date of service 5/31/2013. The Claims Administrator based its reimbursement of the billed code 99215 on 99214 indicating "In regard to our original recommendation for payment under a lower level of service than the one billed, we have re-evaluated the submitted documentation and feel our original review is appropriate per the Medical Fee Schedule, which defines the various levels of service and provides examples of each. Based on these definitions and the information available, we find the original review is accurate."

CPT 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Detailed history; Detailed examination; Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

CPT 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Comprehensive history; Comprehensive examination; Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

The Provider submitted a "Primary Treating Physician Progress Report." The report documented the worker was seen for forty-five minutes and over half of the time was spent on orthopedic counseling, regarding issues of diagnosis, treatment and coordination of care. The Provider documented an examination of right shoulder. Range of motion was tested in the shoulders and neck. The workers grip strength was tested in the right and left extremities. The Provider documented the continued treatment and/or plans as the following: continue using H-Wave; and home exercise. The Provider requested authorization for arthroscopic surgery (right shoulder), repair of rotator cuff, repair of labrum, debridment, excision of distal clavicle and acromioplasty. The Provider documented a review of the plan with the worker.

Per the OMFS Evaluation and Management Guidelines, when counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time is considered the key or controlling factor to qualify for a particular level of E/M services. The extent of counseling and/or coordination of care must be documented in the medical record. Based on a review of the code description of CPT 99215, typical face-to-face time is 40 minutes. The Provider documented over 20 minutes was spent in counseling and/or coordination of care. The documentation supports the reimbursement of the Evaluation and Management code 99215.

The additional reimbursement of \$39.04 is warranted per the Official Medical Fee Schedule code 99215.

