

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 26, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000033	Date of Injury:	01/12/2015
Claim Number:	[Redacted]	Application Received:	01/12/2015
Claims Administrator:	[Redacted]	Assignment Date:	02/25/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99205 -93, WC003, 96101-93 x 12 Units and 96116-93 x 2 Units		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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, MD, MPH
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
- 2014 AMA CPT

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 full remuneration submitted 99205 -93 New Patient Evaluation and Management Services with Interpreter, WC003 Permanent and Stationary Primary Care Physician Treatment Report, 96101 Psychological Testing x 12 Units & 96116 Neuro Behavioral Exam performed x 2 Units – with Interpreter on 06/24/2014.**
- Claims Administrator reassigned CPT 99204 to submitted CPT 99205 with the following rationale: “The documentation does not support the level of service billed. Reimbursement was made for a code that supported by the description and documentation submitted with the billing.”
- The determination of an Evaluation and Management service for New Patients require **all three key components** in the following areas (CMS.Gov):
 - **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - **Examination: All elements** in a general multi system examination, **or complete examination of a single organ system** and other symptomatic or related body area(s) or organ system(s)
 - **Medical Decision Making Medical** decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- a. The number of possible diagnoses and/or the number of management options that must be considered;
- b. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- c. The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.
- Psychiatric Single System Exam Comprised of the following for New Patient **99205**:
 - Constitutional Measurement required (all):
 - B/P__ sitting or standing,
 - B/P__ supine,
 - P__,
 - R__,
 - T__,
 - Ht__
 - Wt__
 - General appearance-grooming, deformities
- Musculoskeletal – 1 bullet required for 99205
 - Assessment of muscle strength and tone (eg, flaccid, cog wheel, spacti) with notation of any atrophy and abnormal movements.
 - Examination of gait and station.
- Psychiatric all bullets (separate documentation from Psychological testing):
 - Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
 - Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation
 - Description of associations (eg, loose, tangential, circumstantial, intact)
 - Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions.
 - Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including Orientation to time, place and person Recent and remote memory Attention span and concentration Language (eg, naming objects, repeating phrases) Fund of knowledge (eg, awareness of current events, past history, vocabulary)
 - Mood and affect (eg, depression, anxiety, agitation, hypomania, liability)
- 1995/1997 Evaluation and Management Levels/Elements: History / Exam / Medical Decision Making, New Patient, All **Three** Components Must Be Met (CMS.Gov):
 - 99202: Problem Focused / Problem Focused / Straight Forward
 - 99203: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
 - 99204: Detailed History / Detailed Exam / Moderate Complexity

- **99205 Comprehensive History/ Comprehensive Exam/ High Complexity**
- **Time:** In the case where 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), time is considered the key or controlling factor to qualify for a particular level of E/M services. The total length of time of the encounter (faced-to-face) should be documented and **the record should describe the counseling and/or activities to coordinate care.**
- Abstracted elements from Date of Service 06/24/2014, did not support a New Patient Level 5 Examination.
- Time Factor for date of service 06/24/2014: Not indicated in report.
- **Modifier -93 Definition:** Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination; **requires a description of the circumstance and the increased time required for the examination as a result.**
- 06/24/2014 Report documented the presence of the interpreter but did not include a description or documentation of the additional time required for the examination as a direct result of the use of an interpreter.
- The documentation requirements for the reporting of Modifier -93 were not met.
- **WC003** Denied by the Claims Administrator based on the following rational: “The Provider was not certified/eligible to be paid for this procedure/service on this date of service.”
- **WC003** Description: **§9789.14 (2) Primary Treating Physician’s Permanent and Stationary Report** (Form PR-3) issued in accordance with section 9785(h).
- Provider is a Consulting Physician, WC003 is not applicable to this Provider.
- §9789.14 5(A) Consultation reports requested by the Workers’ Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32.
- WC007 and Modifier -32 not reflected on CMS1500. As such, reimbursement is not indicated for WC003.
- **99358, 96101 x 12 Units and 96116 x 2 Units** denied by the Claims Administrator with the following rational: “No separate payment was made because the value of the services is included in the value of another service performed on the same day,” and “The procedure code is inconsistent with the modifier used or required modifier is missing.”
- Pursuant to Title 8 CCR Physician Fee Schedule 1/1/2014, § 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.
- CMS 1500 form reflects **96101 -93 x 12 units** (line items) billed with Evaluation and Management Code 99205.

- CMS 1500 form reflects **96116 x 2 units** (line items) billed with Evaluation and Management Code 99205.
- Based on the NCCI edits, a code pair exist between CPT 99205 and 96101 as well 99205 and 96116.
- A Code pair exist between Claims Administrator Assigned CPT 99204 and 96101 as well as 99203 and 96116.
- Modifier Indicator column shows ‘1’ which states if a proper modifier is appended to the correct code and documentation supports the use of the procedure code, then the edit may be overridden.
- The correct modifier was not appended to the column 2 code, CPT 96101 or 96116, as such the column 2 code may not be reviewed as a separately identifiable service from its code pair.
- Modifier -93 not a valid code for CTP 96101 and 96116. Valid Modifiers for 96101 and 96116 are: 25, 27, 50, 52, 58, 59, 73, 74, 76, 77, 78, 79, 91
- E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GG, GH, LC, LD, LM, LT, RC, RI, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9, & TA.
- Based on the aforementioned documentation and guidelines, additional reimbursement is not supported for CPT Code 99205, WC003, 96101 & 96116

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99205 -93 WC003, 96101-93 x 12 Units and 96116-93 x 2 Units

Date of Service: 08/20/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99205-93	\$350.00	\$86.95	\$350.00	1	N/A	\$191.00	Refer to Analysis
WC003	\$220.00	\$0.00	\$220.00	16	N/A	\$0.00	Refer to Analysis
96101-93	\$1800.00	\$0.00	\$1800.00	12	N/A	\$0.00	Refer to Analysis
96116-93	\$300.00	\$0.00	\$300.00	2	N/A	\$0.00	Refer to Analysis

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