

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 28, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-000133	Date of Injury:	06/17/2014
Claim Number:	[Redacted]	Application Received:	01/30/2015
Claims Administrator:	[Redacted]	Assignment Date:	02/25/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99205, WC002, 72100 & 73030 - RT		

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 \$249.58 in additional reimbursement for a total of \$444.58. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$444.58 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, 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 New Patient Evaluation and Management Services, WC002 Primary Care Physician Treatment Report, 72100 Radiologic examination, spine, lumbosacral; 2 or 3 views & 73060 Radiologic examination, shoulder; complete, minimum of 2 views performed on 08/08/2014.**
- Claims Administrator reassigned denied services with the following rational: “These charges represent unauthorized treatment, self-pouring treatment that were not necessary to cure or relieve the effects of an industrial injury.”
- Correspondence from Legal Party dated 01/02/2015 addresses the Provider as “elected” by the (Injured Worker) as “the Primary treating Physician.”
- Correspondence from Claims Administrator dated 11/04/2014 states the following: “you are the treating physician of (Injured Worker” in conjunction with his claimed industrial injury... you are authorized to provide all medical treatment reasonably required...”
- 99205 Evaluation and Management New Patient Evaluation.
- 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.
- 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** (New RX Opioid with Frequent Random Drug Testing, Occupational Therapy Requested & Follow Up visit).
- Abstracted elements from Date of Service 08/08/2014, supports a New Patient Level 5 Examination, reimbursement is warranted.
- OMFS Definition **WC002**: Primary Treating Physician Progress Report.
- Provider is the new Primary Treating Physician. Reimbursement is warranted for WC002.
- Correspondence from Claims Administrator dated 11/04/2014, paragraph 2, line 6, states the following: “You are required to secure prior authorization for any non-emergency treatment or diagnostic service.”
- Documentation provided for IBR does not indicate authorization for CPT 72100 & 73030 – RT. As such, reimbursement is not supported for radiological diagnostic services 72100 & 73030.
- PPO Contractual Agreement Not Available for IBR, OMFS will be utilized in reimbursement calculations.

The table below describes the pertinent claim line information.

