MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 8, 2015

[redacted]

IBR Case Number:	CB15-0001324	Date of Injury:	05/05/2010
Claim Number:	[redacted]	Application Received:	08/11/2015
Assignment Date:	08/31/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	04/10/2015 – 04/10/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99215 and WC002		

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 $137.05 in additional reimbursement for a total of $332.05. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$332.05** 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]

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
- OMFS

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 99215 Evaluation and Management & WC002 Primary Treating Physician Report performed on 04/10/2015.**
- The Claims Administrator denied services based on "unauthorized" service rational.
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 08/13/2015: response not yet received.
- Contractual Agreement not submitted for IBR.
- Provider confirms Primary Treating Physician Status by means of formal communication (letter) addressed to Provider by Claims Administrator dated "March 25, 2013.
- Follow-up evaluation and management services for accepted injury do not require authorization. EOR's do not reflect dispute of reported ICD.9 codes.
- The determination of an Evaluation and Management service for Established Patients require **two** of **three** key **components** in the following areas (AMA CPT 1995/1997):

    1) **History**: Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
    2) **Examination**: "The 1995 documentation guidelines state that the medical record for a general multi-system examination should include findings about eight or more organ systems."
    3) **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.

- To determine the level of service in a given **component** of an E&M, the data must "**meet or exceed**" the elements required.
- 1995/1997 Evaluation and Management Levels/Elements (History / Exam / Medical Decision Making), Established Patient:
    - 99212: Problem Focused / Problem Focused / Straight Forward
    - 99213: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
    - 99214: Detailed History / Detailed Exam / Moderate Complexity
    - **99215 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 information for date of service 04/10/2015 revealed the following service:
    - History:
        - HPI: High Complexity
        - ROS; Brief - "No Changes." Documentation to confirm this status with corresponding elements necessary to determine ROS, not submitted for IBR.
        - Pertinent Other History: Brief - "No Changes." Documentation to confirm this status with corresponding elements necessary to determine ROS, not submitted for IBR.
    - Exam:
        - Examination: Detailed
    - Decision Making:
        - Diagnosis: Multiple
        - Complexity of data: Limited
        - Risk: High - Pain Management (Opioid),

    - **Documentation indicates the following level of service:**

      Brief / Detailed / High = **99214** (2 of 3)

  Time Factor for date of service:

  - **Not Documented**

- **CPT 99215 is not indicated, reimbursement is recommended for documented service 99214.**
- **WC002 Primary Treating Physician Treatment Repot (PR-2)** is a reimbursable report when submitted to reflect continued treatment. Documentation indicates on-gong treatment resulting in two written prescriptions and "modified" work restrictions.
- **Based on the aforementioned documentation and guidelines, reimbursement for documented Evaluation and Management service, 99214 and WC002 PR-2 report is recommended.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99215 and WC002

Date of Service: 04/10/2015 Physician Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
99215 as **99214**	$237.17	$0.00	$237.17	1	$125.14	**Refer to Analysis**
WC002	$15.61	$0.00	$15.61	1	$11.91	**Refer to Analysis**

Copy to:

[redacted]

Copy to:

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