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

# INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 29, 2015

[redacted]

| | | | |
|---|---|---|---|
| IBR Case Number: | CB15-0001479 | Date of Injury: | 02/12/2011 |
| Claim Number: | [redacted] | Application Received: | 08/28/2015 |
| Assignment Date: | 09/17/2015 | | |
| Claims Administrator: | [redacted] | | |
| Date(s) of service: | 03/17/2015 – 03/17/2015 | | |
| 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 $101.72 in additional reimbursement for a total of $296.72. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **$296.72** 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 service and WC002 Primary Treating Physician Report performed on 03/17/2015.**
- The Claims Administrator denied services as unauthorized.
- The Provider is the Primary Treating Physician – authorization for Office Visit is not required.
- 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 03/17/2015 revealed the following service:

    - **History: Expanded Problem Focused**

        - HPI: Expanded Problem Focused
        - ROS: "Unchanged… last visit."
            - Unable to verify elements from "last visit" as documentation not submitted.
        - Other: History Brief

    - **Exam: Exp. Problem Focused**

        - Exp. Problem Focused Musculoskeletal Exam

    - **Medical Decision Making: Moderate Complexity**

        - Multiple: Presenting Problems/Diagnosis
        - Multiple Complexity of data:
        - Risk: High – Opioid Prescription.

    - Expanded Pf. / Expanded Pf. / Moderate Complexity = 2 of 3/Meet or Exceed = 99213

**Time Factor for date of service:**

- **Not Documented**

- **WC002 Primary Treating Physician** Treatment Report. DWC states, "The purpose of the 45-day rule in California Code of Regulations, Title 8, section 9785(f)(8) is to make sure that in the case of continuing treatment, that the patient's progress is monitored no less than once every 45 days." However, "Within a 45-day period, the primary treating physician can bill for as many PR-2's as are **medically necessary**."
- The Provider is the "Primary Treating Physician." Submitted report indicates the Injured Worker "**dispensed**" medication. The dispensed medication reflects on-going treatment. As such, unless indicated per contractual obligation, reimbursement for a PR-2 report is warranted.
- Contractual Agreement not submitted for IBR.
- **Based on the aforementioned documentation and guidelines, reimbursement for Evaluation and Management 99215 is not supported, recommend reimbursement for documented service 99213 and WC002.**

The table below describes the pertinent claim line information.

## DETERMINATION OF ISSUE IN DISPUTE: 99215 & WC002

| **Date of Service**: 03/17/2015<br>Physician Services | | | | | | |
|---|---|---|---|---|---|---|
| **Service Code** | **Provider Billed** | **Plan Allowed** | **Dispute Amount** | **Units** | **Workers' Comp Allowed Amt.** | **Notes** |
| 99215 | $232.17 | $0.00 | $97.37 | 1 | $89.81 | **99213**<br>**Refer to Analysis** |
| WC002 | $15.61 | $0.00 | $15.61 | | $11.91 | **Refer to Analysis** |

Copy to:

[redacted]

Copy to:

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