

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

09/28/2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001491	Date of Injury:	01/09/2014
Claim Number:	[Redacted]	Application Received:	08/31/2015
Assignment Date:	09/17/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	02/18/2015 – 02/18/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204		

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, M.D., M.P.H.
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
- CPT 2015
- 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 99204 New Patient Evaluation services performed on 02/18/2015.**
- The Claims Administrator denied services as “unauthorized.”
- Authorization from a PQME for “EMG” bilateral lower extremities, dated 12/16/2014.
- AMA CPT 2015 Nerve Conduction Tests “must be prepared on site by the examiner, and consist of the work product of **the interpretation** of numerous test results...”
- 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(s)*, 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.
 - Documentation on 02/18/2015 indicates the following:
 - Authorization for EMG bilateral lower extremities
 - No indication of Request for Consultation.
 - Evaluation Performed with **Interpretation** of findings regarding EMG included in report. All three components must met in order to achieve a specified level of service.
 - History – Comprehensive
 - Exam – Detailed
 - Medical Decision Making & Management Options – Straight Forward:
 - # of Diagnoses/Mgmt. Options – Low Complexity (CPT 99203)
 - Complexity of Data Reviewed – Minimal (EMG data not included for IBR) (CPT 99202)
 - Risk – (CPT 99201), Provider indicates “Treatment recommendations are deferred to the patient’s primary treating physician.”
- Unable to recommend reimbursement for Authorized EMG as data not included in IBR.

- **Based on the aforementioned documentation and guidelines, New Patient Evaluation and Management Service, 99204 is not supported.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204

Date of Service: 02/18/2015						
Provider Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99204	\$354.10	\$0.00	\$350.05	1	\$0.00	Refer to Analysis

Copy to:

[REDACTED]

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[REDACTED]