

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 21, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000318	Date of Injury:	06/22/2009
Claim Number:	[Redacted]	Application	03/06/2015
Assignment Date:	04/06/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	06/05/2014 – 06/05/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99214-25		

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
- 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 additional remuneration for 99214-25 Established Patient Evaluation and Management services performed on 06/05/2014.**
- EOR reflects Claims Administrator's reimbursement rational as follows: "No separate payment was made because the value of the procedure is included in the value of another procedure performed on the same day."
- EOR indicates **90833**, add-on Psychotherapy
- **Modifier -25: Significant, separately identifiable evaluation and management** service by the same physician or other qualified health care professional on the same day of the procedure or service.
- AMA CPT 2014 states the following regarding **90833 Psychotherapy, 30 min:**
 - To report both E/M and psychotherapy, **the two services must be significant and separately identifiable.**
 - Time associated with activities used to meet criteria for the E/M service is **not** included in the time used for reporting psychotherapy service (i.e., **time spent on history, examination and medical decision making** when used for the E/M service is not psychotherapy time.) Time may not be used as the basis of E/M code selection..."
- **The determination of an Evaluation and Management service** for Established Patients require **two of three** key components in the following areas:
 - **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.

- **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.”
- **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), 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**
 - i. History 3 Chronic Conditions or Greater than 4 elements relating to: quality, location, duration, severity, timing, context modifying factors, & associated symptoms.
 - ii. **Detailed Exam** (Extended exam of 2 – 7 affected body areas/organ systems and other symptomatic or related organ systems)
 - iii. **Moderate** Complexity
 - 99215 Comprehensive: extended HPI, ROS that is directly related to the problems identified in the HPI plus all additional body systems, and a complete PMFSH.
- **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.
- Documentation entitled “Periodic Report,” sub title “Treatment,” appears to reflect and meet the criteria for psychotherapy service 90832 and not the requirements for add-on code 90833 with a **separately identifiable** parent Evaluation and Management service Code 99214.
- Based on the aforementioned guidelines, reimbursement is not indicated for 99214.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214 - 25

Date of Service: 06/05/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99215	\$150.00	\$0.00	\$150.00	N/A	1	\$0.00	Refer to Analysis
90833	N/A	N/A	N/A	N/A	1	N/A	Not in Dispute
90822	N/A	N/A	N/A	N/A	1	N/A	Not in Dispute

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
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