

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 10, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000377	Date of Injury:	07/09/2013
Claim Number:	[REDACTED]	Application Received:	03/16/2015
Assignment Date:	04/14/2014		
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/07/2014 – 08/07/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215		

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 \$40.15 in additional reimbursement for a total of \$235.15. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$235.15** 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]
[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 services & WC002 Primary Treating Physician Progress Report performed on 08/07/2014.**
- The Claims Administrator applied Evaluation and Management 99213 reimbursement to submitted 99215 with the following rationale: “Documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.”
- EOR dated indicates Provider Reimbursed @ “**Network Allowance**” for WC002 & for 99215 - changed to 99213, by the Claims Administrator.
- The determination of an Evaluation and Management service for Established Patients require **two** of **three** key components in the following areas:
 - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) **Examination:** Problem Focused, Expanded Problem Focused, Detailed Comprehensive “(General multi-system examination, or complete examination of a single organ system or other symptomatic related body area(s) or organ system(s).”

- 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.
- 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; HPI = 4 + elements or status of 3 chronic conditions, ROS = 10 + Systems, PFSH 2 History Areas; Comprehensive Physical Exam - two from EACH of nine organ systems; High Complexity Medical Decision Making, 2 of 3 in the following areas: 4 Problem Points or Management Options, 4 Data (record review, test discussion/ordering etc.) & High Level of Risk.**
 - **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. **Total Visit Time not indicated on 08/07/2014 Permanent and Stationary Report.**
 - Abstracted information date of service 08/07/2014 resulted in the following Established Evaluation and Management service: **99214.**
 - Based on the aforementioned documentation and guidelines Evaluation and Management Service, 99214 is recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: CPT 99215

Date of Service: 08/07/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99215	\$310.00	\$84.99	\$82.16	N/A	1	\$125.14	\$40.15 Due Provider Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]