

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 7, 2015

[Redacted]
[Redacted]
[Redacted]

| | | | |
|-----------------------|-------------------------|-----------------------|------------|
| IBR Case Number: | CB15-0000858 | Date of Injury: | 09/10/2012 |
| Claim Number: | [Redacted] | Application Received: | 05/26/2015 |
| Assignment Date: | 06/26/2015 | | |
| Claims Administrator: | [Redacted] | | |
| Date(s) of service: | 08/25/2014 – 08/25/2014 | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 99204 and WC007-30 | | |

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 \$283.07 in additional reimbursement for a total of \$478.07. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$478.07** 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
- Official Medical Fee Schedule

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 full remuneration for 99204 New Patient Evaluation and WC007, Consultation Reports, for date of service 08/25/2014.**
- Claims Administrator denied the service with the following rationale: “Charged denied as the report/documentation does not indicate that the service was performed
- **Article 5.3 Official Medical Fee Schedule §9789.12.12 (c)(2) Consultation Services, separately reimbursable reports: Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation. Use WC007, Modifier -30**
- Original AME report and referral reviewed. AME Report and referral request written on a prescription form was verified requesting the following service from Provider:
 - EMG/NCV and Neurodiagnostic testing and consultation report of bilateral upper extremities.
 - EMG/NCV and Neurodiagnostic testing and consultation report of bilateral lower extremities.
- The determination for New Patient Evaluation and Management Levels/Elements are as follows: History / Exam / Medical Decision Making. A New Patient Level requires that **All Three Components Must Be Met.**
 - 99202: Problem Focused / Problem Focused / Straight Forward
 - 99203: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
 - 99204: Detailed History / Detailed Exam / Moderate Complexity

- 99205 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 from Consultation Report indicated the following 99203 New Patient Exam consisting of the following components:
 - Detailed History/Detailed Exam/Low Complexity Medical Decision Making.
 - Time factor not indicated in Consultation Report.
- Criteria Met for WC007.
- **§9789.19 (a) Services Rendered On or After 1/1/2014:** WC007 - \$38.68 for first page, \$23.80 each additional page. Maximum of six pages absent mutual agreement (\$157.68)
- Mutual agreement for amount greater than WC007 reimbursement rate not identified.
- Contractual Agreement not indicated; 100 % OMFS will be utilized.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for WC007 – 30 in accordance with §9789.12.12 (c)(2) and 99203 (billed as 99204).**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204 & WC007-30

| Date of Service: 08/25/2014 | | | | | | | |
|-----------------------------|-----------------|--------------|----------------|----------------|-------|----------------------------|-------------------|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Units | Workers' Comp Allowed Amt. | Notes |
| 99204 As 99203 | \$354.10 | \$0.00 | \$191.10 | N/A | 1 | \$125.39 | Refer to Analysis |
| WC007-30 | \$157.68 | 0.00 | \$157.68 | N/A | 1 | \$157.68 | Refer to Analysis |

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