

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 14, 2015

██████████
████████████████████
████████████████████

IBR Case Number:	CB15-0000890	Date of Injury:	07/22/2014
Claim Number:	██████████ ██████████	Application Received:	06/01/2015
Assignment Date:	July 2, 2015		
Claims Administrator:	██████████		
Date(s) of service:	04/01/2015 – 04/01/2015		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	99205, 99354, 72141-26, 73221-26, 95886-26, 95913-26, and WC002		

Dear ██████████

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 oweag Provider additional reimbursement of \$195.00 for the review cost and \$191.11 in additional reimbursement for a total of \$386.11. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$386.11** 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, MD, MPH
Medical Director

cc: ██████████
████████████████████

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
- 2014 AMA CPT

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 submitted 99205, 99354, 72141-26, 73221-26, 95886-26, 95913-26, and WC002 services performed on 04/01/2015.**
- Claims Administrator reassigned denied services based on insufficient documentation.
- The determination of an Evaluation and Management service for New Patients require **all three key components** in the following areas (CMS.Gov):
 - **1. History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - **2. 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)
 - **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.
- 1995/1997 Evaluation and Management Levels/Elements: History / Exam / Medical Decision Making, New Patient, All **Three** Components Must Be Met (CMS.Gov):
 - 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 elements from Date of Service 04/01/2015 revealed the following level of evaluation:
 - Detailed/Detailed/Moderate Complexity = 99204
- **99354**, Prolonged Services – Submitted Consultation Report does not indicate time factor. As such, 99354 services could not be verified.
- New studies and separate reports could not be identified for CPT Codes 72141-26, MRI neck spine w/o dye, 73221-26 MRI joint upper extremity w/o dye, 95886 MRI joint upper extremity w/o dye & 95913 Nerve Conduction test 13/> studies. The Provider indicates reviewing “11/15/2014” MRI studies and “10/9/2014” EMG/NCV conduction studies.
- The PC of a service is for physician work interpreting a diagnostic test or performing a procedure, and includes indirect practice and malpractice expenses related to that work. Modifier 26 is used with the billing code to indicate that the PC is being billed. Modifier – 26 Appended to aforementioned previously determined studies, may not be re-billed by another provider.
- **WC002** is a Primary Treating Physician report. Authorization and report indicates the Injured Worker was referred to the Provider for a “second” opinion, authorized by the Claims Administrator.
- Request for reports could not be identified pursuant to OMFS: Consultation Reports that are separately reimbursable. The following reports are separately reimbursable.
- - (A) Consultation reports requested by the Workers' Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32.
 - (B) 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.
- Contractual Agreement not submitted for IBR; OMFS will be utilized.

