

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 15, 2015

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

IBR Case Number:	CB15-0000962	Date of Injury:	12/06/2012
Claim Number:	██████████	Application Received:	06/11/2015
Assignment Date:	07/10/2015		
Claims Administrator:	██████████		
Date(s) of service:	03/16/2015 – 03/16/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	99215, 99354, 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: 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: ██████████
████████████████████

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 99354 Prolonged Services with face-to-face contact & WC002 Primary Treating Physician Progress Report performed on 03/16/2015.**
- The Claims Administrator applied Evaluation and Management 99213 reimbursement to submitted 99215, denied 99354 due to lack of “information.”
- EOR dated indicates Provider Reimbursed “contracted fee agreement” for WC002.
- 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.
- Abstracted information date of service 3/16/2015 resulted in the following Established Evaluation and Management service:
 - Expanded Problem Focused History/Expanded Problem Focused Exam/Moderate Complexity Medical Decision Making = **99213**.
- Evaluation and Management documentation does not indicate time. As such, time factor for 99354 could not be established.
- EOR's indicate the Provider Reimbursed contractual rate for WC002 & 99213.
- Correspondence from the Provider to the Claims Administrator presented for IBR, indicates the Provider is not aware of a contractual agreement.
- **Pursuant to LC § 5307.11** – “the medical fee schedule shall not apply to the contracted reimbursement rates.” California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:
 - **LC § 5307.11 states:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, **the medical fee schedule for that health care provider or health facility**

licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.

- Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 99215, 99354 & additional reimbursement is not indicated for WC002.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: CPT 99215, 99354 & WC002

Date of Service: 03/16/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99215	\$267.88	\$49.13	\$129.46	N/A	1	\$49.13	Refer to Analysis
99354	\$181.46	\$0.00	\$120.97	N/A	1	\$0.00	Refer to Analysis
WC002	\$18.02	\$10.72	\$4.76	N/A	1	\$10.72	Refer to Analysis

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