

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 27, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000516	Date of Injury:	08/19/2013
Claim Number:	[REDACTED]	Application Received:	03/30/2016
Assignment Date:	04/19/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/11/2015 – 12/11/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, 99354, and 99355		

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 \$133.40 in additional reimbursement for a total of \$328.40. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$328.40** 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,

[REDACTED] 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 99205 New Patient Evaluation and 99354 Prolonged Services with Face-to-Face Contact, 72148-26 Technical Component of Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material and WC002 Primary Treating Physician reports, for date of service 12/11/2015.**
- The Claims Administrator's denied services indicating "the documentation does not support the level of service billed."
- Consultation codes 99241 – 99245 Consultation Codes are no longer utilized, New Patient Evaluation and Management Service Codes 992010 -99205 and, if warranted, a California Workmans' Compensation modifier.
- **CCR § 9789.12.12** Consultation Services Coding – use of visit codes
 - (a) Maximum fees for physicians and qualified non-physician practitioners performing consultation services shall be determined utilizing the appropriate RVU for a patient evaluation and management visit and the RVU(s) for prolonged service codes if warranted under CPT guidelines. Physicians and qualified non-physician practitioners shall code consultation visits as patient evaluation and management visits utilizing the CPT Evaluation and Management codes that represent where the visit occurs and that identify the complexity of the visit performed. CPT consultation codes shall not be utilized
- Provider submitted Evaluation and Management Code 99205 for Consultation.
- The determination of an Evaluation and Management service for New Patients require **All three key components** in the following areas (AMA CPT 1995/1997):
 - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) **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."
 - 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.
- To determine the level of service in a given **component** of an E&M, the **data** must "**meet or exceed**" the elements required.
- 1995/1997 Evaluation and Management Levels/**Elements** (History / Exam / Medical Decision Making), Established Patient:

- 99202: Exp. Problem Focused / Exp. Problem Focused / Straight Forward
- 99203: Detailed / Detailed Exam / **Low Complexity**
- 99204: Comprehensive / Comprehensive Exam / Moderate Complexity
- **99205: Comprehensive / Comprehensive Exam/ High Complexity**
 - High Risk = Presenting Problems: One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment. Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure. An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss
 - Diagnostic Procedure(s) Ordered: Cardiovascular imaging studies with contrast with identified risk factors. Cardiac electrophysiological tests Diagnostic Endoscopies with identified risk factors Discography
 - Management Options: Elective major surgery (open, percutaneous or endoscopic) with identified risk factors Emergency major surgery (open, percutaneous or endoscopic). Parenteral controlled substances. Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis
 - Face-to-Face Time Requirement, 60 minutes.
- **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 for date of service 12/11/2015** revealed the following service:
 - **History:**
 - HPI: Detailed
 - ROS: Problem Pertinent
 - Other History: Problem Pertinent
 - Detailed / Pertinent / Pertinent = **Detailed** History (99203)
 - **Exam: Detailed:**
 - **Detailed** extended of affected area / organ system + related/ symptomatic areas (99203)
 - **Medical Decision Making:**
 - Presenting Problems/Diagnosis = Multiple

- Complexity of data: Multiple
 - Risk: Low
 -
 - Multiple / Multiple / Low = **Moderate** Medical Decision Making (99204)
- New Patient E & M must **meet all three key components:**
 - **Detailed / Detailed / Moderate** = 99203

Time Factor for date of service:

- **Page 1 of Consultation Report, the Provider indicates “2.5 hours” of “Face to Face”** time with Injured Worker. **Procedures 95913:** Nerve conduction studies; 13 or more studies **and 95886:** Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels, **were performed on the same day of Consultation** (submitted as 99205). The documentation is unclear as to how much time was spent on each activity/procedure (99215, 95886, 95913) or if the activities/procedures (99215, 95886, 95913) overlapped or were congruent **in time.**

Documentation of time spent on each activity, 99215, 95886 and 95913, is necessary in order to determine if a significantly separate and identifiable **time-driven** 99205 level of services was performed.

- **99354, Prolonged Services** could not be abstracted from report as the required time component is not documented.
 - **99355 add-on to Parent Code 99354.**
 - **MLN Matters Document MM5972 - Prolonged Services with Direct Face-to-Face Patient Contact Service Documentation** is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. The **start and end times of the visit shall be documented in the medical record** along with the date of service.
- **Based on the aforementioned documentation and guidelines, reimbursement for 99205, 99354 and 99355 is not indicated. Recommend reimbursement for documented services 99203.**

The table on page 6 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99205, 99354, 72148-26, & WC002

Date of Service: 12/11/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99205 -25	\$470.00	\$0.00	\$470.00	1	\$133.40	OMFS Recommend 99203
99354	\$420.00	\$0.00	\$420.00	1	\$0.00	OMFS
99355	\$210.00	\$0.00	\$210.00	1	\$0.00	OMFS

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]
 [REDACTED]