

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 10, 2016

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

IBR Case Number:	CB16-0000590	Date of Injury:	11/01/2011
Claim Number:	[REDACTED]	Application Received:	04/12/2016
Assignment Date:	12/21/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/21/2015 – 12/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205-25, 99354-59, 99355-59, and 96101-59		

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 \$406.97 in additional reimbursement for a total of \$601.97. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$601.97** 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 99205 New Patient Evaluation and 99354 Prolonged Services with Face-to-Face Contact 1st hour, add-on code 99355 each additional 30 min, and 96101 Physiological Testing submitted for date of service 12/21/2015.**
- The Claims Administrator's down-coded 99205 to 99203 based on submitted documentation not meeting "3 key" components.
- Contractual Agreement Not Received for IBR.
- The determination of an Evaluation and Management service for New Patients require **All three key components or time- component** 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 12/21/2015** revealed a time-driven Psychological Consultation.
 - **Page 1 of Consultation Report, the Provider indicates consultation interview lasted a minimum of 105 minutes. ”**
- 99205 time component is 60 minutes.
 - The documented total time over the 60 minute time frame for 99205 is 45 minutes.
 - 1 unit is indicated for **99354, Prolonged Services** to cover the 45 additional face to face minutes.
- **Add-On code 99355 is not indicated** as the total time is represented in full by CPT 99205 and 99354.
- **96101 Denied by the Claims Administrator** indicating “documentation does not indicate the service was performed.”
Page 5 and 6 of the Psychological Consultation, the Provider indicates Psychological Tests were administered with “**Computerized Scoring**” was utilized “to generate a **report**” for the Injured Worker “based on her Reponses and interpretive language” and results were “paraphrased” in the report.
- CPT 96101 Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. The Consultation Report indicates a scoring and report performed by a computer. As such, **96101 is not indicated**. Reimbursement is recommended for documented service **96103 Psychological testing** (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, mmpi), **administered by a computer**, with qualified health care professional interpretation and report, x 1 unit.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99205, 99354 and 96103 and is not indicated for 99355 and 96101.**

