

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 31, 2016

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

IBR Case Number:	CB16-0000730	Date of Injury:	04/11/2014
Claim Number:	[REDACTED]	Application Received:	05/02/2016
Assignment Date:	05/23/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/21/2015 – 01/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99204 and WC007		

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 \$291.08 in additional reimbursement for a total of \$486.08. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$486.08** 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,
MAXIMUS

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 99204 New Patient Evaluation Services and WC007-30 (Consultation Reports Requested by AME or QME), for date of service 01/21/2015.**
- The Claims Administrator denied services in full due to “absence of pre-certification.”
- Submitted referral from AME (referring Provider) to Provider indicates the following request:
 - EMG/NCV and Neurodiagnostic testing and Consultation Report of Bilateral Lower Ext.
- **CCR § 9789.12.12 (c)(2)** 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**.
- CMS 1500 reflects 99204 and WC007; Modifier -30 appended to WC007.
 - EMG/NCV CPT codes not reflected
- 2nd EOR reflects “99070” Supplies and Materials denied as “previously reviewed.”
 - Submitted CMS 1500 does not indicate 99070.
- Referring provider AME status verified via written request to AME from Legal Parties.
 - AME authorized to perform tests AME has deemed “reasonably necessary to properly evaluate” applicant.
- 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
 - **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 01/21/2015** revealed the following service:
 - **History:**
 - HPI: Extended
 - ROS: Extended
 - Other History: Complete
 - Extended/ Extended / Complete = **Detailed** History (99203)
 - **Exam:**
 - **Detailed** extended of affected area / organ system + related/ symptomatic areas (99203)
 - **Medical Decision Making:**

- Presenting Problems/Diagnosis = Limited
 - Referred for EMG/NCV and Consultation for Bilateral Lower Extremities
 - Complexity of data = Limited
 - “No Available Medical Records”
 - EMG Report
 - Risk: Low
 - Recommendations made for AME Review.
 - Detailed / Detailed / Low = **Low Complexity** Medical Decision Making (99203)
- New Patient E & M must **meet all three key components:**
 - **Detailed / Detailed / Low = 99203**

Time Factor for date of service:

- Not Indicated
- WC007 - \$38.68 for first page, \$23.80 each additional page. Maximum of six pages absent mutual agreement (\$157.68).
- Opportunity to Dispute Eligibility communicated with the Claims Administrator on 05/23/2016; response not yet received.
- Contractual Agreement not submitted for IBR; OMFS utilized.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for WC007-30 and 99203 and is not indicated for 99204.**

The table on page 5 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204 and WC007-30

Date of Service: 01/21/2015						
Provider						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99204	\$354.10	\$0.00	\$354.10	1	\$133.40	Recommend 99203 Refer to Analysis
WC007-30	\$158.94	\$0.00	\$158.94	1	\$157.68	Refer to Analysis

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