MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 15, 2015

[redacted]

IBR Case Number:	CB15-0000136	**Date of Injury:**	07/16/2014
Claim Number:	[redacted]	**Application Received:**	12/22/2014
Claims Administrator:	[redacted]	**Assignment Date:**	01/29/2015
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99214		

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 $250.00 for the review cost and $51.32 in additional reimbursement for a total of $301.32. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $301.32 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]

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

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 99214 Evaluation and Management Services provided on 10/20/2014**.
- The Claims Administrator denied the service with the following rational: "We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible."
- The determination of an Evaluation and Management service for Established Patients require **two** of **three** key components in the following areas (AMA CPT 1995):

    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.

- 1995/1997 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**
        i. History 3 Chronic Conditions or Greater than 4 elements relating to: quality,location,duration,severity, ,timing, context modifying factors, & associated sysmptoms
        ii. **Detailed Exam** (Extended exam of 2 – 7 affected body areas/organ systems and other symptomatic or related organ systems)
        iii. **Moderate** Complexity
    - Pertinent PMFSH related to the patient's problems.

- 99215 Comprehensive: extended HPI, ROS that is directly related to the problems identified in the HPI plus all additional body systems, and a complete PMFSH.
- **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.**

Additional Evaluation and Management information can be found in the AMA CPT code book or on-line at CMS.Gov.

- Abstracted information for date of service resulted in the following 99212 Established Patient Evaluation and Management service:

    - **October 30, 2014:**

        - **<u>History</u>**: Problem Focused - minimal documentation
        - **<u>Exam</u>**: Expanded Problem Focused - no indication of testing type, i.e., ROM, NCV, etc., relating to the R/L +/- extremity documentation.
        - **<u>Medical Decision Making</u>**: Straight forward

Time Factor for date of service:

- **October 30, 2014**: Hand written unsigned chart note "No. 83081," indicates "40 min" listed under the heading "medication." Indicated time does not meet the aforementioned criteria under "**Time**" driven Evaluating and Management services.

- Based on the aforementioned documentation and guidelines, reimbursement for Evaluation and Management Level 99212 is recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214

Date of Service: 10/30/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
99214	$126.00	$0.00	$126.00	N/A	1	$51.32	Recommend Reimbursement 99212.

Copy to:

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