MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Sacramento, CA 95813-8006
Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 20, 2015

[redacted]

IBR Case Number:	CB15-000139	**Date of Injury:**	02/08/2012
Claim Number:	[redacted]	**Application Received:**	01/29/2015
Claims Administrator:	[redacted]	**Assignment Date:**	02/23/2015
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: 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, MD, MPH
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 full remuneration for 99214 Evaluation and Management Services performed on 10/27/2014.**
- Claims Administrator applied reimbursement relating to CPT 99213 with the following rational: "The documentation doesn't support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing."
- 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 symptoms**
    - 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 10/27/2014 resulted in a 99212 Established Patient Evaluation and Management service:
  - **History =** Problem Focused
  - **Exam =** Problem Focused **(**limited to affected body area)
  - **Medical Decision Making** = Straight Forward (request for "1 roll cordon tape, follow up 1 month).

- Time Factor for date of service 10/27/2014:
  - Two Hand Written Patient Encounter Forms. **1)** Progress note, "N° 83067" under the heading, "medication," there appears to be entry of "45 min" documented (hand writing not clear). However, there is no description indicting what portion of the visit was spent on "counseling and/or activities to coordinate care (AMA CPT)," or if the

entry is in fact, in relation to the total time of the visit. The documentation is does not clarify what the indicated time, '45' min, is in relation to. Important notation, the progress note does not reflect the Provider's name or Practice and is not signed by the Provider. **2)** PR-2 form; documentation appears to be a formal handwritten representation of handwritten progress note 'N° 83067.' The 45 min time is not indicated on this form. IBR unable to clarify what portion of the indicated time related to the exam and what portion of the time related to counseling or coordination of care.

- Based on the aforementioned documentation and guidelines, Evaluation and Management Service 99214 is not supported.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214

Date of Service: 10/27/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99214	$126.00	$51.32	$74.68	1	N/A	$84.99	**Refer to Analysis**

Copy to:

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