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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 1, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000212	Date of Injury:	07/22/2014
Claim Number:	[REDACTED]	Application Received:	02/17/2015
Claims Administrator:	[REDACTED]	Assignment Date:	03/06/2015
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99203 - 57		

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 \$86.95 in additional reimbursement for a total of \$281.95. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$281.95 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, MD, MPH
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
- NCCI Medicare Billing Manual
- AMA CPT 2014
- 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 99203 -57 New Patient Evaluation for date of service 07/22/2014.**
- Claims Administrator denied service with the following rationale: “The visit or service billed occurred within the global surgical period and is not separately reimbursable.”
- CMS 1500 and EORs indicate CPT 26418 Repair Extensor Finger W/O graft performed on 07/22/2014.
- OFMS indicates a “90” day global period for CPT 26418.
- Modifier -57 code description: Decision for Surgery.
- NCCI Medicare Billing Manual, page I-17, paragraph D, Evaluation and Management (E&M) Services, Global Surgery Rules for reporting evaluation and management services with procures,” states the following: If a procedure has a global period of **90 days**, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M **service is separately reportable with modifier 57**. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.
- Evaluation and Management Documentation and surgical CPT code reviewed, criteria met for Modifier 57.

- The determination of an Evaluation and Management service for New Patients require **all three key components** in the following areas (CMS.Gov):
 - **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - **Examination: All elements** in a general multi system examination, **or complete examination of a single organ system** and other symptomatic or related body area(s) or organ system(s)
 - **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.
- Musculoskeletal
 - Assessment of muscle strength and tone (eg, flaccid, cog wheel, spacti) with notation of any atrophy and abnormal movements.
 - Examination of gait and station.
- Psychiatric all bullets (separate documentation from Psychological testing):
 - Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
 - Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation
 - Description of associations (eg, loose, tangential, circumstantial, intact)
 - Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions.
 - Description of the patient’s judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including Orientation to time, place and person Recent and remote memory Attention span and concentration Language (eg, naming objects, repeating phrases) Fund of knowledge (eg, awareness of current events, past history, vocabulary)
 - Mood and affect (eg, depression, anxiety, agitation, hypomania, liability)
- 1995/1997 Evaluation and Management Levels/Elements: History / Exam / Medical Decision Making, New Patient, **All Three Components Must Be Met** (CMS.Gov):
 - 99202: Problem Focused / Problem Focused / Straight Forward
 - 99203: **Expanded Problem Focused / Expanded Problem Focused / Low Complexity**

- 99204: Detailed History / Detailed Exam / Moderate Complexity
- 99205 Comprehensive History/ 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 07/22/2014 resulted in a 99202 New Patient Evaluation and Management service:
 - History = **Problem Focused**
 - ✓ Chief Complaint
 - ✓ HPI: Problem Focused
 - ✓ ROS: Problem Focused
 - ✓ Past Family Social History: Problem Focused
 - Exam = **Problem Focused**
 - ✓ Exam: “Pertinent musculoskeletal examination of the left upper extremity.”
 - Medical Decision Making = **Moderate Complexity**
 - ✓ Number of Diagnoses or Management Options: 1
 - ✓ Amount and/or complexity of data reviewed: 3 view X-rays of left hand.
 - ✓ Risk of Complication: Moderate
 - ✓ Decision Making: Moderate
 - ✓ Medication – None

- Time Factor for date of service 07/22/2014:
 - Time spent for New Patient Evaluation not indicated.

- Based on the aforementioned documentation and guidelines reimbursement for 99203 is not supported; documentation supports reimbursement for 99202. Reimbursement for 99202 New Patient Evaluation and Management services is recommended.

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

DETERMINATION OF ISSUE IN DISPUTE: 99203-57

Date of Service: 07/22/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99203	\$125.39	\$0.00	\$125.39	1	N/A	\$86.95	99202 Reimbursement Recommended.
26418	N/A	N/A	N/A	1	N/A	N/A	Code Not In Dispute

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