

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 23, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001331	Date of Injury:	05/18/2013
Claim Number:	[Redacted]	Application Received:	8/11/2015
Assignment Date:	08/31/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	03/09/2015 – 03/09/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	72100, 99205, 73510-LT, 72170, an dJ3490 x 2		

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 \$281.11 in additional reimbursement for a total of \$476.11. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$476.11** 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 72100. 99205, 73510-LT, and J3490 x2 performed on 03/09/2015.**
- The Claims Administrator denied services due to “self-procured” medical treatment.
- **RFA dated 02/24/2015, signed by Claims Administrator Agent**, on 02/24/2015, authorized the following services on Low Back & Left Hip: “evaluate and provide indicated care with utilization MTUS guidelines...Urine Toxicology ... X-ray’s...”
- **LC § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a **contracting agent**, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- **Prescriptions** require prior authorization and are not specifically stated in the RFA; **J3490 x 2 Upheld.**
  - The determination of an Evaluation and Management service for New Patients require **all three key components** in the following areas:
    - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
    - 2) **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)
    - 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 Components: History / Exam / Medical Decision Making, New Patient Exams require **All Components Must Be Met:**
  - 99202: Problem Focused / Problem Focused / Straight Forward
  - 99203: Expanded Problem Focused / Detailed / Low Complexity
  - 99204: Comprehensive / Comprehensive / Moderate Complexity
  - 99205: **Comprehensive / Comprehensive / 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.**

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 03/09/2015 resulted the following:
  - History = **Comprehensive**
    - HPI: Comprehensive
    - ROS: Complete
    - Past Family Social History: Complete
    - Comprehensive/ Complete/ complete = Comprehensive (99204/99205)
  - Exam = **Detailed**
    - L-Spine & Left Hip Exam and ROM = Detailed (99203)
  - Medical Decision Making = **Moderate Complexity**
    - Number of Diagnoses or Management Options: Multiple
    - Amount and/or complexity of data reviewed: Multiple
    - Decision Making/Risk: Moderate
    - Multiple/ Multiple/ Moderate = (99204)
    - Abstracted New Patient Evaluation Components = 99203.
- Time Factor for date of service 03/09/2015:
  - Time Not Documented
- The aforementioned 02/24/2015 documentation is contractual in nature. As such, the contractual obligations apply pursuant to LC § 5307.11, for the following services:
  - New Patient Evaluation 99203
  - X-ray's: 72100 & 73510-LT
- **Based on the aforementioned documentation and guidelines, reimbursement for 99203, 72100, & 73510 is supported and is not indicated for J3490 x 2.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 72100, 99205, 73510-LT, 72170, and  
J3490 x 2**

<b>Date of Service: 03/09/2015</b>						
Physician Services						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
72100	\$71.76	\$0.00	\$71.76	1	\$55.20	<b>Refer to Analysis</b>
99205 as 99203	\$328.55	\$112.63	\$328.55	1	\$167.15	<b>Refer to Analysis</b>
73510- LT	\$76.39	\$0.00	\$76.39	1	\$58.76	<b>Refer to Analysis</b>
J3490	\$32.40	\$0.00	\$32.40	2	\$0.00	<b>Refer to Analysis</b>

Copy to:

████████████████████  
 ██████████  
 ██████████████████

Copy to:

██  
 ██  
 ██