

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 13, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001659	Date of Injury:	07/03/2012
Claim Number:	[REDACTED]	Application Received:	09/21/2015
Assignment Date:	10/09/215		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/01/2015 – 04/01/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, 99358, and 99359		

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 \$1,103.21 in additional reimbursement for a total of \$1,298.21. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$1,298.21** 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 99205, 99354 & 99355 Prolonged Services without Direct Face-to-Face Contact performed on 04/01/2015.**
- EOR #1, The Claims Administrator down coded 99205 to 99215, Established Patient.
- SBR submission indicates 04/01/2015 “is the first time seeing patient.”
- EOR #2, The Claims Administrator’s reimbursement rationale for 99205 indicates “scheduled allowance,” for 99215.
- Opportunity to Dispute Edibility submitted to Claims Administrator on 09/21/2015; response not yet received.
- Submitted report does not indicate Provider has previously treated Injured Worker. As such, a New Patient Evaluation is warranted.
- **CCR § 9789.12.13.** Correct Coding Initiative.(a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
- 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.
- 1995/1997 Evaluation and Management Levels/Elements: History / Exam / Medical Decision Making, New Patient, All **Three Components Must Be Met** (CMS.Gov):
  - 99201: Problem Focused / Problem Focused / Straight Forward (10 Min Face-to-Face)

- 99202: Expanded Problem Focused / Expanded Problem Focused / Straight Forward (20 Min)
  - 99203: Detailed / Detailed / Low Complexity (30 Min)
  - 99204: Comprehensive / Comprehensive / Moderate Complexity (45 Min)
  - 99205: Comprehensive History/ Comprehensive Exam/ High Complexity (**60 Min**)
- **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 04/01/2015 revealed the following service:
    - **History: Comprehensive**
      - HPI: Extensive
      - ROS: Complete
      - Other: Complete
    - **Exam: Not Performed**
      - Exam Not Performed for Separate E&M.
    - **Medical Decision Making: Moderate**
      - Multiple: Presenting Problems/Diagnosis = Multiple
      - Multiple Complexity of data:
      - Risk: Low (Not the Treating Physician, Medications not Prescribed, No Mention Provider will assume care)
    - **Comprehensive/ None / Low = 2 of 3/Meet or Exceed = Required Exam Elements for New Patient Evaluation and Management Not Met.**
  - **Time Factor for date of service:**
    - Documentation Reflects “60 Min.” Report reflects Counseling describe the counseling and/or activities to coordinate care.
  - **99205 New Patient Evaluation criteria met based on Time Factor.**
  - The Claims Administrator denied **99358 and 99358** as “bundled” into billed Evaluation and Management service.
  - **Authorization for 99358 & 99359 Prolonged Services, without Face-to-Face Contact signed by Claims Administrator on 03/25/2015.**
    - Authorization does not specify max number of units for 99359.

- **CCR § 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**.
- Although 99358 and 99359 are status “B” indicators and are typically bundled into Evaluation and Management Services, the aforementioned 03/25/2015 Authorization is contractual in nature. As such, contractual obligations apply pursuant to CCR § 5307.11.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 99205, 99358 & 99359.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99205, 99358 & 99359**

Date of Service: 04/01/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99205	\$297.09	\$169.66	\$127.43	1	\$252.73	<b>\$83.07 Due Provider Refer to Analysis</b>
99358	\$156.14	\$0.00	\$156.14	1	\$131.98	<b>Refer to Analysis</b>
99359	\$1056.44	\$0.00	\$1056.44	14	\$888.16	<b>Refer to Analysis</b>

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