



## **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 99215 Established Patient Evaluation and Management, and WC002 Primary Treating Physician Report submitted for date of service 04/06/2015.**
  - The Claims Administrator denied reimbursement with the following rationale:
    - Cannot review without necessary documentation.
    - Service exceeds authorized approval.
  - 08/27/2015 Communication from Legal Parties address to Provider indicates “Primary Treating Physician” status.
  - Authorization for Injured Worker to see designated Primary Treating Physician regarding accepted body parts/injuries is not required.
1. The determination of an Evaluation and Management service for Established Patients require **two** of **three** key **components** in the following areas (AMA CPT 1995/1997):
- 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.
- To determine the level of service in a given **component** of an E&M, the data must “**meet or exceed**” the elements required.
  - 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
    - **99215 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 04/06/2015 revealed the following service:
  - **History: Problem Focused**
    - HPI: Extended
    - ROS: Pertinent
    - Other: Not Documented
  - **Exam: Exp. Problem Focused**
    - Exp. Problem Focused
  - **Medical Decision Making: Moderate**
    - Multiple: Presenting Problems/Diagnosis = Multiple
    - Multiple Complexity of data: Minimal
    - Risk: Moderate
  - **Problem Focused / Expanded Problem Focused / Moderate = 2 of 3/Meet or Exceed = 99213**

**Time Factor for date of service:**

- **Not Documented**
- **Reimbursement for Evaluation and Management 99215 is not indicated, recommend reimbursement for documented service 99213.**
- 04/06/2015 PR-2 indicates Progress Report reflects Injured Worker seen and treated for pain in “cervical spine, bilateral shoulders, and bilateral wrists, psych and sleep.”
- Unless otherwise indicated by Contractual Agreement, WC002 reports are reimbursable under the OMFS every time a patient is seen for medical treatment.
- Contractual Agreement not submitted for IBR.
- **Reimbursement is warranted for WC002.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 99213 & WC002 and not indicated for 99215.**

The table below describes the pertinent claim line information.

