

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 19, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001842	Date of Injury:	06/16/2003
Claim Number:	[Redacted]	Application Received:	10/07/2015
Assignment Date:	11/06/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	06/02/2015 – 06/02/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99205-25, 99354, G0434, 99358 x 12, 99070 x 120, 99070 x 30, 99070 x 60, WC002		

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 \$145.31 in additional reimbursement for a total of \$340.31. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$340.31** 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 99205-25, 99354, G0434, 99358 x 12, 99070 x 120, 99070 x 30, 99070 x 60, & WC002 for date of service 06/02/2015.**
- The Claims Administrator denied services due to lack of authorization.
- Authorization dated March 11, 2015, signed by the Claims Administrator, indicates the Provider is the “elected” Primary Treating Physician. Primary Treating Physicians do not require prior authorizations for in-office assessments (CPT 99201 – 99215) reflecting continued medical care for an accepted injury.
- Provider submitted Evaluation and Management Code 99205. Visit Documentation reflects “Initial Consultation.” Authorization indicates the Provider is assuming medical care as the Primary Treating Physician.
- The determination of an Evaluation and Management service for **New Patients** require **All 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:
 - 99202: Exp. Problem Focused / Problem Focused / Straight Forward
 - 99203: Detailed / **Detailed Exam** / Low Complexity
 - 99204: **Comprehensive** / Comprehensive Exam / Moderate Complexity
 - 99205 **Comprehensive** / 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 06/02/2015** revealed the following service:
 - **History: Comprehensive**
 - HPI: Extensive
 - ROS: Complete
 - Other History: Extensive
 - Extensive / Complete / Extensive = **Comprehensive** History
 - **Exam: Detailed**
 - **Detailed** Ortho/Musculoskeletal Examination
Extended of affected area / organ system + related / symptomatic areas
 - **Medical Decision Making: Comprehensive**
 - Presenting Problems/Diagnosis = Multiple
 - Complexity of data: Extensive
 - Risk: High – Rx and Tx Plan
 - Multiple / Extensive / High = **Comprehensive** Medical Decision Making
- New Patient E & M must **meet all three key components**:
 - **Comprehensive / Detailed / Comprehensive** = **99203**

Time Factor for date of service:

- **Not Documented**
- Documentation does not reflect **99205 New Patient Evaluation and Management Service; recommend reimbursement** for documented service, **99203**.
- **Add- on CPT 99354** Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour, requires documentation of time over and above the allotted time for reported parent code (99205).
- **MLN Matters** Document MM597 - Prolonged Services with Direct Face-to-Face Patient Contact Service Documentation is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. **The start and end times of the visit shall be documented in the medical record along with the date of service.**
- Initial Evaluation did not reflect the necessary time components necessary to determine **99354; Reimbursement Upheld.**
- **Add-on CPT 99358** Prolonged evaluation and management service before and/or after direct patient care; first hour, unless authorized by the Claims Administrator, is bundled into the reported service 99205.

- Authorization dated March 11, 2015 does not reflect service **99358; Reimbursement Upheld.**
- Unless otherwise indicated by a Contractual Agreement, **WC002** reports are reimbursable when an Injured Worker is seen for continued medical care for an accepted injury.
- Contractual Agreement not received for IBR.
- Initial Report indicates Initial New Patient Evaluation; **WC002 Reimbursement is Warranted.**
- Prior authorization is required for 99070 (Neurontin 300mg NDC 3172222205) # 120, 99070 (Ambien 10mg NDC 00603646932) # 30, 99070 (Duloxetine 20mg) # 60, and G0434-QW Urine Drug Screen.
- Authorization dated March 11, 2015 does not reflect authorization for the following: **99070** (Neurontin 300mg NDC 3172222205) # 120, **99070** (Ambien 10mg NDC 00603646932) # 30, **99070** (Duloxetine 20mg) # 60, and **G0434-QW** Urine Drug Screen; **Reimbursement Upheld.**
- **Based on the aforementioned documentation and guidelines, reimbursement for 99205-25, 99354, G0434, 99358 x 12, 99070 x 120, 99070 x 30, and 99070 x 60 is not indicated. Recommend reimbursement for documented service 99203 & WC002.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 27096

Date of Service: 06/02/2015 Physician Services						
Service Codes	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99205-25, 99354, G0434, 99358 x 12, 99070 x 120, 99070 x 30, 99070 x 60, WC002	\$4,009.50	\$0.00	\$2,804.00	Multiple	\$145.31	99203 & WC002 Reimbursement Recommended Refer to Analysis

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