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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 30, 2015

[redacted]

IBR Case Number:	CB15-0002025	Date of Injury:	08/17/2006
Claim Number:	[redacted]	Application Received:	11/02/2015
Claims Administrator:	[redacted]		
Date(s) of service:	04/28/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	62370 and 99215-25		

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 $104.19 additional reimbursement for a total of $299.19. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$299.19** 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]

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
- Partial Contractual Agreement
- National Correct Coding Initiatives

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 99215 -25 Evaluation and Management Service and 62370 Pain Pump Reprogramming performed on 04/28/2015.**
- Claims Administrator denied codes indicating on the Explanation of Review "This service requires prior authorization and none was identified"
- Retro Authorization for "04/28/2015 for pump fill," approved by Claims Administrator on 08/10/2015.
- Provider submitted documentation including a Pump Progress Report, Intrathecal Pump Maintenance and Administration Record, and Session Data Report.
- Provider billed code 99215-25 for an Established Patient Office visit, Significant, separately identifiable Evaluation and Management.
- The determination of an Evaluation and Management service for Established Patients require **<u>two</u>** of **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**: Problem Focused, Expanded Problem Focused, Detailed Comprehensive "(General multi-system examination, or complete examination of a single organ system or other symptomatic 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.

- 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; **HPI** = 4 + elements or status of 3 chronic conditions, **ROS** = 10 + Systems, **PFSH** 2 History Areas; Comprehensive **Physical Exam** - two from EACH of nine organ systems; High Complexity Medical Decision Making, 2 of 3 in the following areas: **4** Problem Points or Management Options, **4** Data (record review, test discussion/ordering etc.,) & High Level of Risk.
- **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**.
- Documentation submitted revealed **99212** level of service as Provider supplied a written prescription to patient. **Reimbursement is recommended for 99212.**
- CPT 62370 - Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional).
- Documentation submitted is supported for billed code and therefore reimbursement is warranted for 62370.
- Partial Contractual agreement did not indicate contracted rate.
- Opportunity to Dispute sent to Claims Administrator on 11/03/2015; response not yet received, OMFS will be utilized to determine payment.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99215-25 & 62370

Date of Service: 04/28/2015							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99212	$350.00	$0.00	$350.00	1	N/A	$30.71	99212 Refer to Analysis
62370	$750.00	$0.00	$77.70	1	N/A	$73.48	Refer to Analysis

Copy to:

[redacted]

Copy to:

[redacted]