

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002070	Date of Injury:	03/31/2015
Claim Number:	[REDACTED]	Application Received:	11/10/2015
Assignment Date:	11/30/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/01/2015 – 06/01/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205-25		

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 \$155.82 in additional reimbursement for a total of \$350.82. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$350.82** 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 New Patient Evaluation for date of service 06/01/2015.**
- The Claims Administrator down-coded 99205 to 99203 indicating “fee schedule allowance.”
- EOR, ICN # 26152101295602, CHK # 0122468784, indicates \$96.91 reimbursed for down-coded 99205 services.
- Contractual Agreement Not Submitted for IBR.
- 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.
- Psychological Testing performed on 06/01/2015 is not considered part of the Evaluation and Management Service.
- **Abstracted New Patient Exam Elements relating to date of service 06/01/2015** revealed the following service:

- **History: Comprehensive**
 - HPI: Extensive
 - ROS: Complete
 - Other History: Complete
 - Extensive / Complete / Complete = **Complete** History

- **Exam: Detailed** Consistent with Psychiatric Exam Criteria
 - **Constitutional**
 - ⊗ **Measurement** of any three of the following seven vital signs:
 - 1) sitting or standing blood pressure, 2) supine blood pressure,
 - 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) **Not performed by Provider or Staff.**
 - ✓ **General appearance of patient** (eg, development, nutrition, body habitus, deformities, attention to grooming).
 - **Musculoskeletal**
 - ⊗ **Assessment of muscle strength and tone** (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
 - ⊗ **Examination of gait and station**
 - **Psychiatric**
 - ✓ Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
 - ✓ Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation
 - ✓ Description of associations (eg, loose, tangential, circumstantial, intact)
 - ✓ Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions
 - ✓ Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition)
 - Complete mental status examination including
 - ✓ Orientation to time, place and person
 - ✓ Recent and remote memory
 - ✓ Attention span and concentration
 - ✓ Language (eg, naming objects, repeating phrases)
 - ✓ Fund of knowledge (eg, awareness of current events, past history, vocabulary)
 - ✓ Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

Comprehensive New Patient Examinations Require All Elements (in shaded area).

- **Medical Decision Making: Moderate**
 - Presenting Problems/Diagnosis = Multiple
 - Complexity of data: Extensive
 - Risk: Moderate
 - High Risk example:
 - Psychiatric illness with potential threat to self or others
 - Not indicated in Report
 - One or more chronic illness with **severe** exacerbation or progression.
 - Not Indicated in Report
 - Current Drug therapy requiring intensive monitoring for toxicity by Provider.
 - Not Indicated in Report.
 - Multiple / Multiple / Moderate = **Moderate** Medical Decision Making
- New Patient E & M must **meet** all three key components:
 - **Comprehensive** (04/05) / **Detailed** (03)/ **Moderate**(04) = **99203**
- **Time Factor for date of service:**
 - Provider states “one and a half hours”
 - EOR Indicates Provider reimbursed for Prolonged Services with Face-to-Face Contact.
 - 99205 = 60 minutes
 - **Criteria Met for 99205 services based on time element.**
- Since the visit documentation reflects the requisite one hour time element and the EOR’s reflect the Claims Administrators acceptance - by virtue of reimbursement, for Prolonged Services with Face-to-Face Contact, it follows and coincides with a logical reimbursement of 99205 services. The abstracted E&M data is irrelevant with the overall time factor.
- **Based on the aforementioned documentation and guidelines, additional reimbursement for 99205 services is not indicated.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99205

Date of Service: 06/01/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99205	\$275.00	\$96.91	\$252.72	1	\$252.73	OMFS \$155.82 Due Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]