

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 16, 2015

[Redacted]  
[Redacted]  
[Redacted]

|                       |                               |                       |            |
|-----------------------|-------------------------------|-----------------------|------------|
| IBR Case Number:      | CB15-0002141                  | Date of Injury:       | 04/05/2012 |
| Claim Number:         | [Redacted]                    | Application Received: | 11/20/2015 |
| Claims Administrator: | [Redacted]                    |                       |            |
| Date(s) of service:   | 06/03/2015                    |                       |            |
| Provider Name:        | [Redacted]                    |                       |            |
| Employee Name:        | [Redacted]                    |                       |            |
| Disputed Codes:       | 99205-25, 99354, and 96101-59 |                       |            |

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 \$111.36 in additional reimbursement for a total of \$306.36. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$306.36** 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 New Patient Evaluation 99205-25, Prolonged Service with Direct Face-to-Face with Patient 99354, and Psychological Testing 96101-59 for date of service 06/03/2015.**
- The Claims Administrator down-coded 99205 to 99203 indicating “Adjusted to comply with the rate and rules of the contract indicated.”
- 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 06/03/2015 is not considered part of the Evaluation and Management Service.
- **Abstracted New Patient Consultation/Examination Elements relating to date of service 06/03/2015** revealed the following service:
  - **History: Comprehensive**
  - **Exam: Detailed** Consistent with Psychiatric Exam Criteria
  - **Medical Decision Making: Moderate**
  - New Patient E & M must **meet all three key components:**
    - **Comprehensive / Detailed / Moderate = 99203**
  - **Time Factor for date of service:**
    - Provider states “2 hours”
    - EOR Indicates Provider billed for Prolonged Services with Face-to-Face Contact
    - 99205 = 60 minutes
    - **Criteria Met for 99205 services based on time element.**
- **Based on the aforementioned documentation and guidelines, additional reimbursement for 99205 services is warranted.**
- Claims Administrator denied 99354 with indication “we cannot review this service without necessary documentation.”
- 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.

