

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 3, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000959	Date of Injury:	06/25/2012
Claim Number:	[Redacted]	Application Received:	05/21/2015
Assignment Date:	07/24/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	02/04/2015 – 02/04/20015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99205, 99354, 72148-26, and 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 \$125.39 in additional reimbursement for a total of \$320.39. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$320.39** 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]  
[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 §9789.12.1 For Services Rendered On or After January 1, 2014.

## 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 full remuneration submitted 99205 New Patient Evaluation and Management Services, 99354 Prolonged Services with direct patient contact, 72148-26 Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material & WC002 Primary Care Physician Treatment Report, performed on 02/02/2015.**
- 2 EOR's Presented for IBR do not indicate reimbursement of charges. Reason for denial unclear and reflect "duplicate charge."
- Authorization from Claims Administrator to Referring Physician indicates Authorization for Consultation.
- The determination of an Evaluation and Management service for New Patients require **all three key components** in the following areas (CMS.Gov):
  - **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
  - **Examination:** All elements in a general multi system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)
  - **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.
- 1995/1997 Evaluation and Management Levels/Elements: History / Exam / Medical Decision Making, New Patient, All **Three Components Must Be Met** (CMS.Gov):
    - 99202: Problem Focused / Problem Focused / Straight Forward
    - **99203**: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
    - 99204: Detailed History / Detailed Exam / Moderate Complexity
    - **99205 Comprehensive History/ Comprehensive Exam/ High Complexity** (New RX Opioid with Frequent Random Drug Testing, Occupational Therapy Requested & Follow Up visit).
  - Abstracted elements from Date of Service 02/04/2015, reveals the following **99203** service:
    - Comprehensive History/ Expanded Problem Focused Exam/Moderate Complexity
  - Time Factor for **Prolonged Service Code 99354** is not documented in Consultation Report. As such, 99354 services cannot be verified.
  - Consultation Report indicates past MRI image of 05/13/2014 “reviewed.” **CPT 72146-26** technical component cannot be re-billed on a previously reimbursed service. As such, reimbursement is not warranted for 72146-26.
  - § 9789.12.12 **Consultation Services Coding** – use of visit codes (b) Consultation reports are bundled into the underlying evaluation and management visit code, and are not separately payable, except as specified in subdivision (c).
    - (c) The following consultation reports are separately reimbursable:
      - (1) Consultation reports requested by the Workers’ Compensation Appeals Board or the Administrative Director. Use WC007, modifier -32.
      - (2) Consultation reports requested by the Qualified Medical Evaluator (“QME”) or Agreed Medical Evaluator (“AME”) in the context of a medical-legal evaluation. Use WC007, modifier -30.
  - OMFS Definition **WC002**: Primary Treating Physician Progress Report. The Provider is a Secondary Treating Consulting Physician. As such, WC002 does not apply and is not reimbursable.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99205, 99354, 72148-26, and WC002**

<b>Date of Service:</b> 07/24/2015							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99205	\$237.67	\$0.00	\$237.67	1	N/A	\$125.39	<b>99203 Recommended OMFS</b>
99354	\$114.35	\$0.00	\$114.35	1	N/A	\$0.00	<b>Refer to Analysis</b>
WC002	\$11.91	\$0.00	\$11.91	1	N/A	\$0.00	<b>Refer to Analysis</b>
72148-26	\$119.15	\$0.00	\$119.15	1	N/A	\$0.00	<b>Refer to Analysis</b>

Copy to:

██████████  
 ██████████  
 ████████████████████

Copy to:

██  
 ██  
 ██