

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 14, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001378	Date of Injury:	01/07/2015
Claim Number:	[REDACTED]	Application Received:	08/18/2015
Assignment Date:	09/07/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/13/2015 – 07/13/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, 99354, 72141-26, 95886-26, 95913-26, 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, 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 and 99354 Prolonged Services with Face-to-Face Contact, 72141-26 MRI Chest/Spine-Technical Component, 95886-26 Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels – Technical Component, 95913-26 Nerve conduction studies; 13 or more studies – Technical Component, and WC002 Primary Treating Physician reports, for date of service 07/13/2015.**
- The Claims Administrator’s denied services requesting “necessary documentation.”
- Communication from Claims Administrator to Provider confirms Provider’s status as a Consulting Physician.
- Authorization specifically listing the CPT Codes in question not submitted for IBR.
- Consultation codes 99241 – 99245 Consultation Codes are no longer utilized, New Patient Evaluation and Management Service Codes 992010 -99205 and, if warranted, a California Workmans’ Compensation modifier.
- § 9789.12.12 Consultation Services Coding – use of visit codes
  - (a) Maximum fees for physicians and qualified non-physician practitioners performing consultation services shall be determined utilizing the appropriate RVU for a patient evaluation and management visit and the RVU(s) for prolonged service codes if warranted under CPT guidelines. Physicians and qualified non-physician practitioners shall code consultation visits as patient evaluation and management visits utilizing the CPT Evaluation and Management codes that represent where the visit occurs and that identify the complexity of the visit performed. CPT consultation codes shall not be utilized
- Provider submitted Evaluating and Management Code 99205 for Consultation.
- 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: Problem Focused / Problem Focused / Straight Forward
  - 99203: Expanded Problem Focused / **Detailed Exam** / Low Complexity
  - 99204: Detailed History / **Comprehensive Exam** / Moderate Complexity
  - **99205 Comprehensive History/ 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 07/13//2015** revealed the following service:
  - **History: Detailed**
    - HPI: Detailed
    - ROS: Complete
    - Other History: Pertinent
    - Detailed / Complete / Pertinent = **Detailed** History
  - **Exam: Detailed**
    - **Detailed** Ortho/Musculoskeletal Examination
  - **Medical Decision Making:**
    - Presenting Problems/Diagnosis = Multiple
    - Complexity of data: Multiple
    - Risk: Low
    - Multiple / Multiple / Low = **Moderate** Medical Decision Making
  - New Patient E & M must **meet** **all three key components:**
    - **Detailed / Detailed / Moderate = 99203**

**Time Factor for date of service:**

- **Not Documented**

- **99354, Prolonged Services** could not be abstracted from report as a time component is not documented.
- **Reimbursement is based on RBRVS.** The consultation report reflects old records where a technical and professional component had previously been rendered. A second Technical Component for records previously interpreted by a Provider, cannot be billed for “review” by a second Provider; this second Technical Component, is not allowed. Rational is based on the following submitted codes: **72141-26, 95886-26, & 95913-26.** A review of this nature could be included with record review in a timed based code where time the spent on review is fully documented.
- **WC002** is reimbursable for Primary Treating Physicians. The documentation reflects the Provider is a Consulting Provider and is considered a Secondary Treating Physician. Request for reports could not be found in documentation submitted for IBR.
- **§ 9789.12.12 Consultation Reports** are only reimbursable under the following circumstances:
  - (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.
- **Based on the aforementioned documentation and guidelines, reimbursement for 99205, 99354, 72141-26, 95886-26, 95913-26, and WC002 is not indicated, recommend reimbursement for documented service 99203.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99205, 99354, 72141-26, 95886-26, 95913-26, and WC002**

<b>Date of Service:</b> 07/13/2015						
Physician Services						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99205, 99354, 72141-26, 95886-26, 95913-26, and WC002	\$1,174.72	\$0.00	\$1,174.72	1	\$0.00	<b>OMFS</b>
99203	N/A	N/A	N/A	1	\$125.39	<b>Refer to Analysis</b>

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