

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 4, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002239	Date of Injury:	03/19/2008
Claim Number:	[REDACTED]	Application Received:	12/07/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	09/25/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215		

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 \$45.20 additional reimbursement for a total of \$240.20. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$240.20** 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
- 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 Evaluation and Management Service performed on 09/25/2015.**
- Claims Administrator's reimbursement on the Explanation of Review "submitted documentation does not support the level of service/charge billed"
- Provider billed code 99215 for an Established Patient Office visit, Evaluation and Management.
- The determination of an Evaluation and Management service for Established Patients require **two** of **three** key components in the following areas:
 - 1) **History**
 - 2) **Examination**
 - 3) **Medical Decision Making**
- 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. Typically, 40 minutes are spent face-to-face with the patient and/or family.
- **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.**
- Provider’s Progress Report submitted documents the patient was “seen for fifty minutes and over half that time (35 minutes) was spent with orthopedic counseling.”
- Based on guidelines and documentation, reimbursement is recommended **for 99215.**
- Partial Contractual agreement received shows a reimbursement rate of 99%.
- Opportunity to Dispute sent to Claims Administrator on 12/09/2015; 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

Date of Service: 09/25/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99215	\$177.83	\$131.60	\$46.23	1	N/A	\$176.80	\$45.20 Due to Provider

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