

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

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 for 99213 Evaluation and Management Services performed on 06/15/2015.**
- Claims Administrator denied CPT 99213 with the following rationale: “carrier not liable for claim or service/treatment.”
- The determination of an Evaluation and Management service for Established Patients require **two** of **three** key components in the following areas (AMA CPT 1995):
 - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) **Examination:** “The 1995/1997 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.
- 1995/1997 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: extended HPI, ROS that is directly related to the problems identified in the HPI plus all additional body systems, and a complete PMFSH.
- **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.**

Additional Evaluation and Management information can be found in the AMA CPT Code book or on-line at CMS.Gov.

- **Time Factor for date of service 06/15/2015:**
 - A Hand Written Progress note states counseling time and topics of discussion that resulted in "15 min."
- Opportunity for Claims Administrator to Dispute Eligibility sent on 2/10/2016. A response from Claims Administrator was not received for this review.
- Based on the aforementioned documentation and guidelines, Evaluation and Management Service 99213 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99213

Date of Service: 06/15/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99213	\$84.00	\$0.00	\$84.00	1	N/A	\$84.00	\$84.00 Due Provider Refer to Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
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