

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 4, 2016

[Redacted]

IBR Case Number:	CB16-0000194	Date of Injury:	06/15/2015
Claim Number:	[Redacted]	Application Received:	02/10/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	09/14/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99205-93		

[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 \$124.06 in additional reimbursement for a total of \$319.06. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$319.06 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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

[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
- AMA CPT

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 submitted 99205 New Patient Evaluation and Management Services performed on 09/14/2015.**
- Claims Administrator denied code with the following rational: “A charge was made for two visits on the same day.”
- Provider billed E & M code along with radiologic exam, knee, complete, 4 or more views, 73564.
- Communication dated August 26, 2015 from Claims Administrator to Provider documents “UR Decision: Approved, Item 1: Take over care of an orthopedist, right knee, per 08/17/15 order. QTY: 1.00 From: 08/26/2015 TO: 10/25/2015”
- The determination of an Evaluation and Management service for New Patients require **all three key components** in the following areas:
 - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) **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)
 - 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, New Patient, All Components Must Be Met:
 - 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**
 - **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.

- Abstracted information for date of service resulted in a 99203 New Patient Evaluation and Management service:
 - History = **Detailed**
 - Exam = **Detailed**
 - Medical Decision Making = **Low Complexity**
 - Time Factor for date of service: Time Not Documented
- Modifier -93 Definition: Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination; requires a description of the circumstance and the increased time required for the examination as a result.
- 09/14/2015 report does not document the presence of an interpreter and did not include a description or documentation of the additional time required for the examination as a direct result of the use of an interpreter.
- The documentation requirements for the reporting of Modifier -93 were not met.
- Based on the aforementioned documentation and guidelines, Evaluation and Management Service 99205 is not indicated however, is indicated for 99203.

- Partial PPO contract received shows a 7% discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99205

Date of Service: 09/14/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99203	\$345.00	\$0.00	\$252.73	1	N/A	\$124.06	\$124.06 Due to Provider

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