

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 18, 2016

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

IBR Case Number:	CB16-0000890	Date of Injury:	07/27/2015
Claim Number:	[REDACTED]	Application Received:	05/31/2016
Assignment Date:	07/05/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/03/2015 – 08/03/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99203		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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,
MAXIMUS

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 99203 New Patient Evaluation services submitted for date of service 08/03/2015.**
- Final EOR indicates services reimbursed based on “documentation.”
- Opportunity to Dispute communicated with the Claims Administrator on 06/17/2016; Response not yet received.
- Communication from Provider in response to IBR’s request for Contractual Agreement indicated a contractual agreement does not exist between parties. The SBR did not reflect that the dispute is contractual in nature in addition to code re-assignment. Rational will proceed to reflect SBR request.
- The determination of an Evaluation and Management service for New Patients require **All three key components** in the following areas (AMA CPT 1995/1997):
 - 99202: Exp. Problem Focused / Exp. Problem Focused / Straight Forward
 - 99203: Detailed / Detailed Exam / Low Complexity
 - 99204: Comprehensive / Comprehensive Exam / Moderate Complexity
 - 99205: Comprehensive / Comprehensive Exam/ High Complexity
- To determine the level of service in a given component of an E&M, the data must “meet or exceed, “the required elements.
- **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 12/23/2015** revealed the following service:
 - **History:**
 - HPI: Extended
 - ROS: Extended
 - Other History: Complete
 - Extended/ Extended / Complete = **Detailed** History (99203)
 - **Exam:**
 - **Expanded Problem Focused** extended of affected area / organ system + related/ symptomatic areas (99202)
 - Documentation of exam as reflected in the Progress note: “right elbow, mild mod ecchymosis, mod swelling, nl. rom, popor strenght, poor supinayion nad pronation.” (**verbatim**)
 - **Medical Decision Making:**
 - Presenting Problems/Diagnosis = Limited

- Complexity of data = Multiple
- Risk: Low
- Limited/ Multiple / Low = **Low Complexity** Medical Decision Making (99203)

- New Patient E & M must **meet all three key components:**

- **Detailed (99203) / Expanded Problem Focused (99202) / Low (99203)= 99202**

Time Factor for date of service:

- Not Indicated
- **Based on the aforementioned documentation and guidelines, reimbursement for 99203 is not indicated.**

The table on below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99203

Date of Service: 08/03/2015							
Physician							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99203	\$180.00	\$70.52	\$62.88	N/A	1	\$70.52	Refer to Analysis

Copy to:

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