MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 28, 2021

REDACTED
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IBR Case Number	CB21-0000239
Claim Number	REDACTED
Assignment Date	04/21/2021
Claims Administrator	REDACTED
Date(s) of service	10/13/2020 - 10/13/2020
Provider Name	REDACTED
Employee Name	REDACTED
Disputed Codes	99215 and WC002
Date of Injury	11/13/2019
Application Received	02/12/2021

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 $180.00 for the review cost and $200.83 in additional reimbursement for a total of $380.83. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$380.83** 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,

MAXIMUS Federal Services

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
- Contractual Agreement

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 is seeking remuneration for 99215 and WC002 submitted for date of service 10/13/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 04/05/2021. Response not yet received.
- CMS 1500, place of service 11
    - 99215-25-95
    - 99401
    - WC002
    - 96130-59-95
- EORs reflect denial of services with the rationale: this service requires prior authorization, and none was identified.
- Code Description
    - 99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires these 2 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
    - WC002: Primary Treating Physician's Progress Report (Form PR-2), issued in accordance with section 9785(f), using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785.
- CCR § 9785. Reporting Duties of the Primary Treating Physician.
    - (1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter.
- Submitted letter from the Claims Administrator dated 03/05/2020, indicates the rendering provider was chosen to provide treatment to the injured worker. Submitted Visit Note appears to meet the definition of a Primary Treating Physician's Report. **WC002 Overturned.**
- CMS Interim Final Rule
    - On an interim basis, we are revising our policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record … For the duration of the PHE for the COVID-19 pandemic, the typical times for purposes of level selection for an office/outpatient E/M are the times listed in the CPT code descriptor.
- Submitted Visit Note dated 10/13/2020 indicates "E/M Time Spent: 45 min was spent with the patient on evaluation and management of the patient's care. More than half of the time was spent in education, counseling and coordination of care for the patient … Patient has agreed to have today's visit conducted via telemedicine due to the Covid-19 outbreak. Provider has also agreed. Visit will be performed on an audio/video enabled device."
- Justification for CPT 99215 has been met based on time component for a telehealth office visit. **99215 Overturned**.

- Submitted contractual agreement indicates medical treatment shall be the lesser of 90% billed charges, 125% CMS, or 90% OMFS. 90% billed charges and OMFS meet the lesser of:
  - CMS: $162.17 * 1.25 = $202.71
  - Billed Charges: $210.25 * .90 = $189.23
  - OMFS: $210.25 * .90 = $189.23
- OMFS 2020 Geographic Practice Cost Index by locality corresponding to the county where service was provided:
  - Provider Zip: REDACTED
  - Locality: REDACTED, CA
  - 99215 Work RVU + GPCI: 2.20917; Non-Facility PE RVU + GPCI: 2.1756; MP RVU + GPCI: 0.10875
  - WC002: $12.89
- Zero reimbursement received. Reimbursement is due up to 90% OMFS.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99215 and WC002.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99215 and WC002
Date of Service: 10/13/2020
Physician

Service Code	99215
Provider Billed	$210.25
Plan Allowed	$0.00
Dispute Amount	$210.25
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$189.23
Notes	**Overturn** 4.49352 (RVU & GPCI Total) * 46.7900 (CF) = $210.25 * .90 (PPO) = **$189.23** **Due Provider** Refer to Analysis

Service Code	WC002
Provider Billed	$12.89
Plan Allowed	$0.00
Dispute Amount	$12.89
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$11.60
Notes	**Overturn** $12.89 (OMFS) * .90 (PPO) = **$11.60** **Due Provider** Refer to Analysis

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