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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 29, 2016

[redacted]

IBR Case Number:	CB16-0000486	Date of Injury:	02/07/2011
Claim Number:	[redacted]	Application Received:	03/22/2016
Assignment Date:	04/21/2016		
Claims Administrator:	[redacted]		
Date(s) of service:	02/12/2015 – 02/12/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99215 and WC002		

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 $101.72 in additional reimbursement for a total of $296.72. A detailed explanation of the decision is provided later in this letter.

he Claim Administrator is required to reimburse the Provider a total of **$296.72** 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,

[redacted], M.D., M.P.H.
Medical Director

cc: [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 99215 Evaluation and Management services & WC002 Primary Treating Physician Progress Report performed on 02/12/2015.**
- The Claims Administrator denied services as "unauthorized."
- Communication dated September 8, 2013, signed by the Claims Adjuster, addressed to the Provider, verifies Primary Physician Designation pursuant to LC § 4600.
- Contractual Agreement Not submitted for IBR.
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 04/05/2016; response not yet received.
- The determination of an Evaluation and Management service for Established Patients require **two** of **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**: Problem Focused, Expanded Problem Focused, Detailed Comprehensive "(General multi-system examination, or complete examination of a single organ system or other symptomatic 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.

- 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.
- **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. **Total Visit Time not indicated on 02/12/2015 PR-2 Report.**

- Abstracted information date of service **02/12/2015** resulted in the following Established Evaluation and Management service: **99213.**
  - **History: Problem Focused**
    - HPI: Straight Forward
    - ROS: Brief
      - "No Change" reference not available for review.
    - Other: Brief
      - Not Indicated
  - **Exam: Exp. Problem Focused**
    - Exam: Exp. Problem Focused
      - Limited - affected area / organ system + other related / symptomatic areas.

- **Medical Decision Making: Moderate Complexity**
    - Minimal: Presenting Problems/Diagnosis = Multiple
    - Minimal Complexity of data: Limited
    - Risk: High – Tramadol management
- Problem Focused/ Expanded PF / Mod Complexity = 2 of 3/Meet or Exceed = 99213

- **99215 Evaluation and Management service is not reflected in the documentation, recommend reimbursement for documented service 99213.**
- Documentation indicates Provider is the Primary Treating Physician and Injured Worker was seen for on-going medical treatment. DWC states, "The purpose of the 45-day rule in California Code of Regulations, Title 8, section 9785(f)(8) is to make sure that in the case of continuing treatment, that the patient's progress is monitored no less than once every 45 days." However, "Within a 45-day period, the primary treating physician can bill for as many PR-2's as are medically necessary."
- Unless otherwise dictated by Contractual Obligation, PR-2 reports are reimbursable when an Injured Worker is treated for continued medical care.
- PR-2 report reflects the visit was medically necessary; RFA generated for Flubiprofen/Lidocaine Cream (20%/5%) 180 gm and Pain Management Consult for Steroidal Lumbar Injection.
- **Based on the aforementioned guidelines, reimbursement is recommended for documented service 99213 and California Specific Reporting Code WC002.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: CPT 99215 & WC002

Date of Service: 02/12/2016							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
99215	$217.29	$0.00	$217.29	N/A	1	$89.81	**99213** **Refer to Analysis**
WC002	$15.48	$0.00	$15.61	N/A	1	$11.91	**Refer to Analysis**

[redacted]

[redacted]