

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 21, 2016

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

IBR Case Number:	CB16-0000522	Date of Injury:	10/28/2001
Claim Number:	[REDACTED]	Application Received:	03/28/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/02/2015 – 12/02/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99204 and 95923		

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,

Paul Manchester, M.D., M.P.H.
Medical Director

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 99204 New Patient Evaluation and 95923 Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (qsart), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential, submitted for date of service 12/02/2015.**
- **CPT 99204 reassigned to 99201** by the Claims Administrator based on “documentation.”
- The determination of an Evaluation and Management service for **New Patients require All three Key Components** in the following areas (AMA CPT 1995/1997):
 - 1) **History:** Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) **Examination:** “The 1995 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.
- To determine the level of service in a given **component** of an E&M, the **data** must “**meet or exceed**” the elements required.
- 1995/1997 Evaluation and Management Levels (History Component / Exam Component / Medical Decision Making Component), New Patient:
 - 99201: Problem Focused / ROS Not Required / Minimal
 - 10 Min Face-to-Face Requirement
 - 99202: Exp. Problem Focused / Exp. Problem Focused / Straight Forward
 - 20 Min Face-to-Face Requirement
 - 99203: Detailed / Detailed Exam / Low Complexity
 - 30 Min Face-to-Face Requirement
 - **99204: Comprehensive / Comprehensive Exam / Moderate Complexity**
 - **45 Min Face-to-Face Requirement**
 - 99205 Comprehensive / Comprehensive Exam / High Complexity
 - 60 Min Face-to-Face Requirement
- **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 Exam Elements relating to 12/02/2015 New Patient Evaluation** revealed the following service:
 - **History:**
 - HPI: Brief (1-3 Elements)
 - ROS: Not Documented (-)
 - Other History: Pertinent (diabetes hx).
 - Brief / (-) / Pertinent = **Problem Focused History**
 - **Exam: Expanded Problem Focused.**
 - Extended of affected area / organ system + related / symptomatic areas
 - ***Medical Decision Making:**
 - Presenting Problems/Diagnosis = Minimal
 - Complexity of data: Required Element Not Indicated (-)
 - No indication of record review.
 - **Electro Diagnostic Studies are not included in this element as this services was reported separately.**
 - Risk: Required Element Not Indicated (-)
 - Recommendations/Treatment Plan Not Documented
 - Rx or OTC meds not discussed or recommended
 - Minimal / (-) / (-) = Required Component Cannot be Determined
 - New Patient E&M **must meet all three Key Components**. Components abstracted from 12/02/2015 documentation:
 - Problem Focused History
 - Expanded PF Exam
 - Medical Decision Making Component Criteria Not Met
 - Time Factor for date of service:
 - Not Indicated

A New Patient Evaluation could not be identified

- Presented documentation does not reflect a separately identifiable New Patient Evaluation and Management service as the * **Required** “Medical Decision Making” element is incomplete and a level of service cannot be determined. Medical Decision Making component is a required **Key Component** for New Patient Evaluations 99201 through 99205.
CPT 99204 Determination Upheld.
- **CPT 95923** denied by Claims Administrator with the following rational: “Plan procedures not followed.”
- Authorization signed by the Claims Administrator, dated 10/23/2015, does not reflect 95923 services as authorized.
- Provider’s Appeal Letter indicates the Injured Worker’s history of Diabetes “**support the medical necessity** of SSR testing and 1 unite code 95923.” (Emphasis added)
- **Administrative Rules § 9792.6.** Utilization Review Standards – Definition (a) “Authorization” means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed “Request for Authorization,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the “Request for Authorization,” DWC Form RFA if that form was initially submitted by the treating physician.
- Authorization from the Claims Administrator approving the specific course of treatment relating to 95923 was not submitted for IBR.
- Authorization for 95923 service is required for reimbursement; **IBR unable to determine medical necessity. CPT 95923 Determination Upheld.**
- **Administrative Rules Article 5.5.0. § 9792.5.7.** Requesting Independent Bill Review (b) Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 99204-25 and 95923.**

The table on page 6 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204 – 25 & 95923

Date of Service: 12/02/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99204 - 25	\$354.10	\$46.41	\$155.36	1	\$0.00	Refer to Analysis
95923	\$372.22	\$0.00	\$252.61	1	\$0.00	Refer to Analysis

Copy to:

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