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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 24, 2014

Dear [Name],

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 $250.00 for the review cost and $76.90 in additional reimbursement for a total of $326.90. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $326.90 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,

[Name]

cc: [Name]
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
- Negotiated contracted rates: none included in case documents
- National Correct Coding Initiatives
- Other: CMS 1997 Documentation Guidelines for Evaluation and Management Services, 2014 CPT published by AMA

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**: Office visit CPT code 99214 down coded to a CPT code 99212 by the claim administrator.
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT 2014 Edition was reviewed.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99214.
- Based on the PR-2 and the additional typed Progress Note for service date 4/23/14 the disputed E/M Level of 99214 is supported in the chart note. The patient presented with three injuries from trauma: wrist fracture, scaphoid fracture and disruption of distal radioulnar joint. The physician documented a Detailed history which included history of present illness elements and referenced the Patient History intake form which included a full Review of Systems and Past, Family Social History. This fulfills a Detailed History per CMS Coding Guidelines. The Examination documentation was Expanded Problem Focused (EPF) and did not include enough bullets for a Detailed Examination. The third key component was Decision Making which proved to be Moderate. The physician
evaluated three injuries, two were improving and one has inadequate response to therapy with significant pain. Per CPT 2014, a Level 99214 requires two of the three key components. The key components of History and Medical Decision Making fulfill the E/M level of 99214 per AMA and CMS standards.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 99214 to be allowed. An additional reimbursement of $76.90 is due to the provider.

<table>
<thead>
<tr>
<th>Date of Service: 4/23/2014</th>
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<tbody>
<tr>
<td>Service Code</td>
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