

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

2/7/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 5/13/2013 – 5/13/2013
MAXIMUS IBR Case: CB13-0000461

Dear [REDACTED], MD:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/7/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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
- Other: OMFS Evaluation and Management Services

Supporting Analysis:

The dispute regards the amount paid for Evaluation and Management services on date of service 5/13/2013. The provider billed CPT 99214, was reimbursed \$51.24 and is requesting additional reimbursement of \$38.33. The Claims Administrator down coded the billed code of CPT 99214 to CPT 99213 indicating "99214 changed to 99213 better defining services performed."

CPT 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity.

CPT 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity.

The Provider submitted a Primary Treating Physician's Progress Report (PR-2) for date of service 5/13/2013. The patient's presenting problem was documented as "pain in the left index finger." The medical record documented a detailed history which included; chief complaint, extended history of present illness; extended system review (ROS) and pertinent past, family, and/or social history. The medical record demonstrated an expanded problem focused physical examination of the left index finger. The workers presenting problems were considered "Low Severity", due to the risk of morbidity without treatment is low and there is little to no risk of mortality without treatment. The diagnosis and problem assessment was left index closed distal phalanx fracture. Treatment plan included a review of X-ray of left index finger, and a DIP finger brace was dispensed and adjusted by the Provider. The patient's symptoms were documented as improving. The medical decision making appears to be of low to moderate complexity.

Although, the medical record documented a detailed history, the medical record did not illustrate a detailed exam or medical decision making of moderate to high severity. The medical record only documented one of the three required components (Detailed history) of the Evaluation and Management code 99214. The medical record documented a detailed history, expanded problem focused examination and medical decision making of low to moderate severity. The code assignment and reimbursement of CPT 99213 by the Claims Examiner was correct.

There is no additional reimbursement warranted for the Official Medical Fee Schedule code 99213.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99213	1	\$38.33	\$51.24	\$51.24	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Evaluation and Management Guidelines and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$51.24 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

██████████, RHIT

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