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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 6, 2014

[redacted]

IBR Case Number:	CB13-0000474	**Date of Injury:**	05/27/2010
Claim Number:	[redacted]	**Application Received:**	09/13/2013
Claims Administrator:	[redacted]		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99215-93, 99081, 99070 x 4 (510790396200, 51079010719, 00406036762 & 00781223301)		

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.

IBR Case Assigned: 07/24/2014

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 $335.00 for the review cost and $245.74 in additional reimbursement for a total of $580.74. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $580.74 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]
Chief Coding Reviewer

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
- Official Medical Fee Schedule
- Negotiated contracted rates: None
- National Correct Coding Initiatives
- Other: OMFS General Information and Instructions

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 dissatisfied with denial of CPT codes 99215-93, 99081, 99070 x 4 (510790396200, 51079010719, 00406036762 & 00781223301)
- Claims Administrator denied procedure codes and indicates on the Explanation of Review "Controverted Claim."
- Documentation included a Primary Treating Physician's Progress Report (PR-2). The PR-2 documented an evaluation and management service performed on date of service 03/27/2013. The report documents an expanded problem focused history which included; chief complaint, brief history of present illness/injury, and problem pertinent system review (Review of Systems). Medical record explains an expanded problem focused exam of the low back, hip, leg and knee. Medical decision making was of low to moderate complexity as Provider documents "Discuss importance of taking all meds as directed" describing the acetaminophen and Norco usage as well as "Continue ice, heat, ESTIM and IEP." Based on documentation submitted and the OMFS guidelines, the evaluation and management services did not meet the requirements or definition of procedure code 99215. PR-2 describes two of the three components of the evaluation and management CPT code 99213. 99213, is described as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: expanded problem focused history; expanded problem focused examination; and medical decision making of low complexity. Usually the presenting problem(s) are of low severity. Reimbursement is warranted based on the evaluation and management procedure 99213.
- Modifier 93 is documented with the evaluation and management procedure. Modifier 93 states: Interpreter required at the time of the examination; where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.1.
- CPT 99081 is also in dispute as Provider has billed for the Progress Report he submitted. OMFS General Information and Instructions, "A progress report shall be submitted no later than 45 days from the submission of the last progress report." Provider submitted a PR-2 documenting patient's history, physical exam and recommendations for continued use of current medications.

The report submitted by the Provider met the criteria for a PR-2. Reimbursement for 99081 is warranted.

- Provider also billed for refills of medications 510790396200, 51079010719, 00406036762 & 00781223301. NDC 510790396200 is an over the counter drug which Provider did not submit a prescription or invoice in this review. Therefore, reimbursement for NDC 510790396200 is not recommended. Provider has documented on the PR-2 these medications are to help with pain to severe pain and quantity and time to be taken. Reimbursement for codes 51079010719, 00406036762 & 00781223301 is allowed.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, reimbursement for CPT codes 99215-93, 99081 and 99070 x 3 (51079010719, 00406036762 & 00781223301) is warranted.

Date of Service: **3/27/2013**						
Physician Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
99213-93	$ 142.35	$0.00	$142.35	1	$ 62.62	**DISPUTED SERVICE**: Allow reimbursement $62.62
99081	$11.69	$0.00	$11.69	1	$11.69	**DISPUTED SERVICE:** Allow reimbursement $11.69
51079039620	$ 5.65	$ 0.00	$ 5.65	60	$0.00	**DISPUTED SERVICE**: No reimbursement allowed
51079010719	$ 11.17	$ 0.00	$ 11.17	60	$11.17	**DISPUTED SERVICE**: Allow reimbursement $11.17
00406036762	$42.24	$0.00	$42.24	60	$42.24	**DISPUTED SERVICE**: Allow reimbursement $42.24
00781223301	$118.02	$0.00	$118.02	30	$118.02	**DISPUTED SERVICE**: Allow reimbursement $118.02

Copy to:

[redacted]

[redacted]