

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Reversed**

3/26/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 7/18/2013 – 7/18/2013  
MAXIMUS IBR Case: CB13-0000524

Dear [REDACTED]

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/14/2014, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$53.71, for a total of \$388.71.**

**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
- Official Medical Fee Schedule or negotiated contract: OMFS
- Other: OMFS Information and Instructions, Evaluation and Management guidelines

### **Supporting Analysis:**

The dispute regards the denial of an Evaluation and Management service (99214), and report services (99081 and 99087) performed on date of service 7/18/2013. The Claims Administrator denied the billed procedure codes 99214, 99081 and 99087 with the explanation “No additional reimbursement allowed after review appeal/reconsideration. Missing/incomplete support data for bill.”

The Independent Bill Review (IBR) case was referred to the Department of Workers’ Compensation (DWC) for an eligibility review. The case was deemed eligible by the DWC for the IBR process.

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.

CPT 99081 - Required reports.

CPT 99087 - Reproduction of duplicate reports.

The Provider submitted a Primary Treating Physician's Progress Report (PR-2) for date of service 7/18/13. The Evaluation and Management services appear to be a follow-up visit and check on acupuncture treatment. The medical record documented a problem focused history which included; chief complaint, brief history of present illness. The medical record demonstrated a problem focused examination of the bilateral upper extremities. The treatment plan documented: continued acupuncture; continued anti-inflammatory and stomach – protective medications; and light duty work. The medical decision making was straight-forward due to the limited number of diagnosis, minimal review of data and minimal risk of complications and/or morbidity or mortality. The medical record demonstrated the required components of Evaluation and Management code 99212. The description of the CPT 99212 is “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: Problem focused history; problem focused examination; and straightforward medical decision making. Reimbursement is warranted for the Evaluation and Management service (99212).

The second disputed code is the billed code 99081. The Provider submitted a report titled “Primary Treating Physician’s Progress Report (PR-2).” The report documented the subjective complaints, physical exam, diagnoses, treatment plan, and work status. Based on the documentation, reimbursement is warranted for a PR-2 bill with the procedure code 99081.

The third disputed code is the billed code 99087. Per the Official Medical Fee Schedule General Information and Instructions, request for duplicate reports related to billing shall be in writing. Requests for duplicate reports shall be made only by the Claims Administrator. A written request for a duplicate report was not received as part of the documentation. The denial of the billed procedure code 99087 by the Claims Administrator was correct.

The additional reimbursement of \$53.71 is warranted for the Official Medical Fee Schedule codes 99212 and 99081. There is no additional reimbursement warranted for the billed procedure code 99087.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99212	1	\$179.14	\$42.02	\$0.00	\$42.02	OMFS
99081	1	\$11.69	\$11.69	\$0.00	\$11.69	OMFS
99087	1	\$10.00	\$0.00	\$0.00	\$0.00	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT codes 99212 and 99081 (\$53.71) for a total of \$388.71.

***The Claims Administrator is required to reimburse the provider \$388.71 within 45 days of date on this notice per section 4603.2 (2a). 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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