

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

5/14/2014

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

IBR Case Number:	CB13-0000838	Date of Injury:	10/19/2009
Claim Number:	[REDACTED]	Application Received:	12/9/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	7/26/2013 – 7/26/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99214		

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/27/2013, 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 Information and Instructions, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the payment amount for an evaluation and management service (99214). The Provider billed the procedure code 99214, was reimbursed \$54.08 and is requesting an additional reimbursement of \$32.64. The Claims Administrator reimbursed \$54.08 for the billed procedure 99214 with the explanation “Level of E&M code submitted is not supported by documentation.”

CPT 99214 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Detailed history; detailed examination; and 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).” The medical record documented the history which included; chief complaint, extended history of present illness; problem pertinent review of systems (ROS); and pertinent past, family, and/or social history. The record did not illustrate all of the required elements of a Detailed History. The medical record demonstrated an Expanded Problem Focused examination of the spine. The worker’s current complaint/illness was documented as “ongoing right sided med and low back pain.” The visit was documented as a follow-up visit. The medical record documented the following diagnoses: lumbar radiculopathy; status post lumbar fusion (1995 another physician); lumbar HPNs; and thoracic DDD. The presenting problems are considered moderate severity as the risk of morbidity and/or mortality without treatment is moderate. The Provider's request for authorization included: Thoracic and lumbar CT; 30 day trial of TENS unit; continued home exercise program; continued medications; and follow-up visit.

The medical record did not demonstrate two of the three components described under CPT 99214. The medical record demonstrated an Expanded Problem Focused History and Examination. The medical decision making was of low complexity due: limited number of diagnosis and management options; limited amount of data reviewed; and low to moderate risk of complications and/or morbidity or mortality. Per a review of the Claims Administrator’s explanation of review (EOR), the reimbursement was based on the Evaluation and Management code 99213. The reimbursement of procedure code 99213 was correct.

There is no additional reimbursement recommended per the billed Official Medical Fee Schedule code 99214.

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
99214	1	\$32.64	\$54.08	\$54.08	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Information and Instructions, Evaluation and Management Guidelines and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$54.08 is upheld.

