

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 12, 2014

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB13-0000843	<b>Date of Injury:</b>	6/12/2001
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	12/10/2013
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	4/30/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	99214		

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.

**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 \$89.57 in additional reimbursement for a total of \$424.57. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$424.57 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]  
[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: CMS 1997 Documentation Guidelines for Evaluation and Management Services, 1997 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 99214 denied for same day of surgery or within the follow up of a previously billed surgery.
- The CMS 1997 Guidelines and the American Medical Association (AMA) CPT were reviewed.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99214. No evidence of a previously billed surgery by Provider was found. This visit was a scheduled medication management visit.
- Based on the PR-2 for office visit 3/5/2013, the disputed E/M Level of 99214 is supported in the chart note. The patient's history was Detailed including History of Present illness, Review of Systems and a Pertinent Past and Social History. A detailed pain assessment was included. The patient received a Detailed examination using the 1997 CMS Coding Guidelines. The neck, shoulder, back and legs were examined in detail. Decision making was moderate based on the complexity of multiple injuries and prescription pain management. Medical Decision Making is based on number of diagnoses managed at this visit, the risk to the patient and if the conditions are stable or have inadequate response. The

