MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 6, 2014

[redacted]

IBR Case Number:	CB14-0001039	**Date of Injury:**	10/20/2012
Claim Number:	[redacted]	**Application Received:**	07/24/2014
Claims Administrator:	[redacted]		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	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.

IBR Assigned: 08/26/2014

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 $250.00 for the review cost and $36.14 in additional reimbursement for a total of $286.14. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $286.14 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: Concare contract
- National Correct Coding Initiatives
- Other: CMS 1997 Documentation Guidelines for Evaluation and Management Services, 2012 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 CPT code 99214 down coded to a CPT code 99213 by the claim administrator.
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT 2012 Edition was reviewed.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99214.
- The patient presented with multiple injuries that were not stable including "pain in neck, diminished biceps weakness, limited hip abduction, limited ROM on extremities and positive impingement". His "epicondyle pain was improving." The physician documented a detailed history including, two pertinent Review of Systems and a Social History including patient's history of ETOH and Smoking. The examination documentation utilized the 1997 E/M guidelines which require 12 or more bullets in the Musculoskeletal Specialty Exam. This examination included 18 bullets which satisfies the code requirement. Medical Decision Making is based on number of diagnoses managed at this visit and if conditions are stable or have inadequate response. The patient had continued pain in neck, shoulder and hip and improved pain in wrist. The risk to the patient is Moderate due to number of chronic conditions managed and that had inadequate response to treatment. This satisfies requirements for Moderate Decision Making. These key components fulfill the E/M level of 99214 per AMA and CMS standards.
- 10% discount to be applied to OMFS fee for code 99214.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99214 to be allowed.

Date of Service: 2/17/2014							
Physician: [redacted]							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99214	$ 124.78	$ 76.49	$ 48.29	N/A	N/A	$ 112.63	**DISPUTED SERVICE**: Allow reimbursement of additional amount $36.14.

Copy to:

[redacted]

Copy to:

[redacted]