

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 14, 2014

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

<b>IBR Case Number:</b>	CB14-0001053	<b>Date of Injury:</b>	11/18/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	07/28/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	09/02/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	99215		

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 \$250.00 for the review cost and \$38.14 in additional reimbursement for a total of \$288.14. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$288.14 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]  
[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: Appendix A in case file
- National Correct Coding Initiatives
- Other: CMS 1997 Documentation Guidelines for Evaluation and Management Services, 2014 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 99215 down coded to a 99213 by Claim Administrator.
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT 2014 Edition were reviewed.
- Based on review of the medical record documentation the services rendered satisfy the requirements for CPT code 99214 not 99215 as originally submitted.
- The PR-2 documentation for date of service 4/11/14 included History elements that were Detailed. A comprehensive History for a Level 9915 would require 4 History of Present Illness elements, 10 review of systems and a Complete Past Family or Social History which were not documented. The examination performed was very detailed and specific for the three finger fractures. The requirements for a Comprehensive Exam for a 99215 require 29 elements to be documented. See below regarding the MSK portion required per CMS 1997 Coding Guidelines:

*Examination of joint(s), bone(s) and muscle(s)/ tendon(s) of four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:*

- *Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions*
- *Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture*
- *Assessment of stability with notation of any dislocation (luxation), subluxation or laxity*
- *Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements*

*NOTE: For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.*

- The examination was detailed based on the 1997 E/M Coding Guidelines for a Musculoskeletal Examination. Medical Decision Making was Moderate based on a condition with inadequate response to therapy and for the interpretation of x-rays. The visit did not appear to be a HIGH level of decision making (99215). High level Decision Making would include “one or more chronic conditions with severe exacerbation, progression or side effects of treatment, or an injury that may pose a threat to life or bodily function.” Per CPT 2014, this office visit meets the three key components necessary for a Level 99214.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99214 to be allowed. Use of CPT code 99215 and 99213 not substantiated. Additional reimbursement of \$38.14 allowed since the provider had been reimbursed based on CPT code 99213.

<b>Date of Service:</b> 4/11/2014							
[REDACTED]							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surg</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99215	\$ 240	\$ 80.74	\$ 78.05	N/A	N/A	\$ 118.88	<b>DISPUTED SERVICE:</b> Allow reimbursement for E/M code 99214. Additional reimbursement of \$38.14 to be reimbursed to the provider.

Copy to:

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[REDACTED]

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