

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 17, 2014

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

IBR Case Number:	CB14-0001131	Date of Injury:	2/8/2012
Claim Number:	[Redacted]	Application Received:	8/11/2014
Claims Administrator:	[Redacted]	Assignment Date:	11/19/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99214, 99214, 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 \$250.00 for the review cost and \$48.67 in additional reimbursement for a total of \$298.67. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$298.67 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]
[Redacted]

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

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:** Reduced reimbursement for CPT code 99214 for dates of service 11/25/13 and 2/13/14.
- The Official Medical Fee Schedule and CPT were reviewed.
- Based on review of the Medical Record:
 - DOS 11/25/13 meets Level 99213 criteria.
 - DOS 2/13/14 meets Level 99213 criteria
- The PR-2 submitted included documentation that did not support the Level 99214 for the office visit dated 11/25/13. History of Present Illness (HPI) requires 4 HPI and 2 Review of Systems and a Pertinent Past, Family Social History to be considered “Detailed.” The history documentation was Expanded Problem Focused. The examination included a Problem Focused Exam using the 1995 CMS Coding Guidelines. The Medical Decision Making addressed two conditions that were worsening which satisfy Low Medical Decision Making. CPT includes a typical time for each level. However, to qualify for a Level 99214 based on time, the visit must be dominated by counseling or coordination of care. Documentation stated simply “40 min.” Per CPT, *“When counseling or coordination of care dominates (more than 50%) the encounter with patient and or family (face to face time...) then **time** shall be considered the key or controlling factor to qualify for a particular level of service. ... The extent of counseling or coordination of care must be documented in the medical record.”* No evidence that over 50% of the visit was spent counseling or coordinating care and what that content of counseling/ coordination entailed. The final key components are Expanded Problem Focused History, Problem Focused Exam and Low Medical Decision Making. Per CPT, a Level 99213 meets the requirements of two out of the three key components.
- The PR-2 submitted included documentation that did not support the Level 99214 for the office visit dated 2/13/2014. History of Present Illness (HPI) requires 4 HPI and 2 Review of Systems and a Pertinent Past, Family Social History to be considered “Detailed.” The history documentation satisfies an Expanded Problem Focused History. The examination of the skin and musculoskeletal system satisfies an Expanded Problem Focused exam as per CMS 1995 Coding Guidelines. The Medical Decision Making addressed treatment and surgery options satisfying a Moderate Decision Making. CPT includes a typical time for each level. However, to qualify for a Level 99214 based on time, the visit must be dominated by counseling or coordination of care. Documentation stated simply “40 min.” Per CPT, *“When counseling or coordination of care dominates (more than 50%) the encounter with patient and or family (face to face time...) then time shall be considered the key or controlling factor to qualify for a particular level of service. ... The extent of counseling or coordination of care must be documented in the medical record. No evidence that over 50% of the visit was spent counseling or coordinating care and what that content of counseling/ coordination entailed. The final key components are Expanded Problem Focused History, Expanded Problem Exam, and Moderate Medical Decision Making. Per CPT, a Level 99213 meets the requirements of two out of the three key components.*

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of CPT codes 99214 on 11/25/13 and 2/13/14 were not substantiated however the use of CPT code 99213 is substantiated for both services. Therefore additional reimbursement of \$48.67 is due to the Provider.

Date of Service: 11/25/13 & 02/13/2014							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99214 for DOS: 11/25/13	\$ 126.00	\$ 42.02	\$ 47.55	N/A	N/A	\$ 56.93	DISPUTED SERVICE: Allow additional reimbursement of \$14.91 (based on 99213).
99214 for DOS: 2/13/14	\$ 126.00	\$ 51.23	\$ 38.34	N/A	N/A	\$ 84.99	DISPUTED SERVICE: Allow additional reimbursement of \$33.76 (based on 99213).

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