

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 10, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001155	Date of Injury:	06/08/2010
Claim Number:	[REDACTED]	Application Received:	08/18/2014
Claims Administrator:	[REDACTED]	Assignment Date:	09/22/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	[REDACTED]		

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 \$106.62 in additional reimbursement for a total of \$356.62. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$356.62 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, 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 99214 down coded to CPT code 99212 four different dates of service (12/18/2013, 01/22/2014, 03/19/2014, 04/23/2014).
- 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 satisfied the requirements for CPT code 99213.
- PR-2 indicated the physician managed multiple injuries including carpal tunnel, cubital tunnel, lateral epicondylitis and desmitis. History of Present Illness (HPI) requires 4 HPI and 2 Review of Systems to be considered "Detailed." Documentation of History is Expanded Problem Focused. The examination of the patient was illegible and vague. The exam documentation only specified "right." As patient presented with right elbow pain credit is given for a Problem Focused Exam using 1997 CMS Coding Guidelines. Five exam bullets equates to a Problem Focused Exam. The Medical Decision Making addressed the improvement of the forearm pain, the thumb was stable and the elbow had increased pain. XR's were reviewed and prescriptions managed. This is Moderate Decision Making as is the total time spent with the patient. However, to qualify for a Level 99214 based on time, the visit must be dominated by counseling or coordination of care. Documentation stated simply "35 min." Per CPT 2014, "*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 that counseling/coordination entailed. The final key components are Expanded Problem Focused History, Problem Focused Exam and Moderate Medical Decision Making. Per CPT 2014, a Level 99213 meets the requirements of the three key components.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of for services based on CPT code 99213. An additional reimbursement of \$106.62 is warranted.

Date of Service: 12/18/13, 1/22/14, 3/19/14, and 4/23/2014					
[REDACTED]					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
99214 (3units)	\$ 126.00	\$ 51.32	\$ 74.68	\$ 84.99	DISPUTED SERVICE: Additional reimbursement due based on assignment of CPT code 99213. Additional amount of \$33.67 * 3 = \$101.01.
99214 DOS = 12/18/13	\$ 126.00	\$ 51.32	\$ 126.00	\$56.93	DISPUTED SERVICE: Additional reimbursement due based on assignment of CPT code 99213. Reimbursement based on 2013 OMFS. Additional reimbursement of \$5.61 due

Copy to:

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