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 14, 2014

[redacted]

IBR Case Number:	CB14-0001165	**Date of Injury:**	03/12/2013
Claim Number:	[redacted]	**Application Received:**	08/18/2014
Claims Administrator:	[redacted]	**Assignment Date:**	09/26/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99214-25, & 90833		

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 $84.99 in additional reimbursement for a total of $334.99. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $334.99 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: none
- National Correct Coding Initiatives, Physician version 20.1
- 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 99214-25was denied services by the Claim Administrator because it was submitted with code 90833.
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT 2014 Edition were reviewed.
- Based on review of the National Correct Coding Initiative, code 99213 can be assigned with code 90833.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99213-25 not 99214-25 as originally submitted. The physician provided Evaluation and Management services with Psychotherapy services.
- The PR-2 documentation for date of service 5/13/14 included History elements that were Expanded Problem Focused. The "subjective complaints "included associated signs, modifying factors, timing and one Review of Systems. These elements satisfy requirements for an Expanded Problem Focused History. The examination was Detailed based on 9 bullet points using the 1997 E/M Coding Guidelines for a Psychiatric Examination. Medical Decision Making was Low based on two problems that were improving and medical management. The final key components are Expanded Problem Focused History, Detailed Exam and Low Medical Decision Making. Per CPT 2014, a Level 99213 meets the

requirements for the three key components. By adding the modifier 25 to the E/M code, the physician is entitled to submit a separately identifiably services provided on the same day such as Psychotherapy, 90833. The physician documented 18 minutes of Psychotherapy. He provided interventions such as "non-pharmacologic interventions including motivations for some walking and stretches … and continue pool therapy". He provided interactive communications with the patient. This meets the requirements for CPT code 90833.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99213-25 to be allowed in addition to reimbursement for code 90833. Additional reimbursement owed to Provider is $84.99.

Date of Service: 5/13/2014							
[redacted]							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
99214-25	$ 150.00	$ 0	$ 150.00	n/a	n/a	$ 84.99	**DISPUTED SERVICE**: Allow reimbursement for E/M code 99213-25. Additional reimbursement of $84.99.
90833	$ 100.00	$ 74.27	$ 0.00	n/a	n/a	$74.27	No additional warranted. Service paid appropriately by the Claim Administrator.

Copy to:

[redacted]

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