

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 5, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001308	<b>Date of Injury:</b>	06/03/2009
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	09/08/2014
<b>Claims Administrator:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	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 Case Assigned: 11/26/2014

**Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule

## 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:** The reimbursement of CPT 99214 for dates of service 9/20/2013 and 4/8/2014.
- Based on review of the medical record the service on 9/20/2013 and 4/8/2014 meets Level 99213 criteria.
- The PR-2 submitted included documentation that did not support the Level 99214 for the office visit dated 9/20/2013. History of Present Illness (HPI) requires a minimum of 4 HPI elements, 2-9 Review of Systems and a Pertinent Past, Family Social History to be considered "Detailed." The history documentation stated location of injury and modifying factors. This satisfies an Expanded Problem Focused History. The examination included an examination of the right/left side which is Expanded Problem Focused. The Medical Decision Making addressed the continued use of splints with ongoing management of four conditions satisfying 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 "45 min." Per CPT coding guidelines for E&M codes, "*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

