

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 18, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000079	Date of Injury:	03/26/2014
Claim Number:	[REDACTED]	Application Received:	01/20/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	3/25/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	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: 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,

Paul Manchester, MD, MPH
Medical Director

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:
- National Correct Coding Initiatives

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:** Provider is dissatisfied with reimbursement of code 99214.
 - Provider billed code 99214 and Claims Administrator down coded to a 99213 indicating on the Explanation of Review “Documentation doesn’t support the level of service”
 - 1995/1997 Evaluation and Management Levels/Elements (History / Exam / Medical Decision Making), Established Patient:
 - 99212: Problem Focused / Problem Focused / Straight Forward
 - 99213: Expanded Problem Focused / Expanded Problem Focused / Low complexity
 - 99214: Detailed History / Detailed Exam / Moderate Complexity**
- History 3 Chronic Conditions or Greater than 4 elements relating to: quality, location, duration, severity, timing, context modifying factors, & associated symptoms
- Detailed Exam** (Extended exam of 2 – 7 affected body areas/organ systems and other symptomatic or related organ systems)
- Moderate Complexity**
- Pertinent PMFSH related to the patient's problems.
- **Time:** In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

The total length of time of the encounter (faced-to-face) should be documented and the record should **describe the counseling and/or activities to coordinate care.**

- On review of Provider's PR-2 submitted, documentation does not qualify for a 99214.
- Based on information reviewed, additional reimbursement is not warranted for 99214.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 99214 is not recommended.

Date of Service: 9/19/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99214	\$126.00	\$84.99	\$41.01	1	N/A	\$0.00	DISPUTED SERVICE: Reimbursement not recommended

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]