

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 13, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

|                       |               |                       |            |
|-----------------------|---------------|-----------------------|------------|
| IBR Case Number:      | CB15-0000088  | Date of Injury:       | 09/02/2011 |
| Claim Number:         | [REDACTED]    | Application Received: | 01/21/2015 |
| Claims Administrator: | [REDACTED]    |                       |            |
| Assigned Date:        | 2/19/2015     |                       |            |
| Provider Name:        | [REDACTED]    |                       |            |
| Employee Name:        | [REDACTED]    |                       |            |
| Disputed Codes:       | 99214 & WC002 |                       |            |

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 \$195.00 for the review cost and \$96.90 in additional reimbursement for a total of \$291.90. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$291.90 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,

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

## 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 denial of codes 99214 and WC002
- Claims administrator denied codes indicating on the Explanation of Review “The charges represent unauthorized, self-procured medical treatment which was not necessary to cure or relieve the effects of an industrial injury...”
- Documentation submitted for this review included notification from claims administrator dated Thursday, August 15, 2013 stating: “Please be advised that the request for transfer of care to Provider is approved”
- Denial of treatment by claims administrator was incorrect for an office visit along with report required by the physician according to Labor Code Section §9785, Reporting Duties of the Primary Treating Physician, and therefore reimbursement is warranted.
- Provider submitted a PR-2, Primary Treating Physician’s Progress Report, to support billing a 99214. 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity.
- Provider’s report does not support a detailed history or exam and therefore, reimbursement is recommended for a 99213.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99213 and WC002 is recommended

| <b>Date of Service: 3/17/2014</b> |                        |                     |                       |              |                         |                                   |  |
|-----------------------------------|------------------------|---------------------|-----------------------|--------------|-------------------------|-----------------------------------|--|
| <b>Physician Services</b>         |                        |                     |                       |              |                         |                                   |  |
| <b>Service Code</b>               | <b>Provider Billed</b> | <b>Plan Allowed</b> | <b>Dispute Amount</b> | <b>Units</b> | <b>Multiple Surgery</b> | <b>Workers' Comp Allowed Amt.</b> | <b>Notes</b>   |
| 99213                             | \$162.68               | \$0.00              | \$162.68              | 1            | N/A                     | \$84.99                           | <b>DISPUTED SERVICE:</b> Allow reimbursement \$84.99 |
| WC002                             | \$15.48                | \$0.00              | \$15.48               | 1            | N/A                     | \$11.91                           | <b>DISPUTED SERVICE:</b> Allow reimbursement \$11.91 |

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]  
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