

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 19, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001208	Date of Injury:	10/19/1995
Claim Number:	[Redacted]	Application Received:	07/24/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	10/29/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99215 (downcoded to 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 99215 as 99214.
- Claims Administrator down coded 99215 to 99214 indicating on the Explanation of Review “Changed from 99215, to better reflect services rendered”
- 99215 - 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 comprehensive history; a comprehensive examination; Medical decision making of high complexity.
- Comprehensive History: is the highest level of history and requires a chief complaint, an extended HPI (four HPI elements OR the status of three chronic or inactive problems), plus a 10 system ROS, plus a Complete PFSH.
- The Comprehensive Physical Exam is the highest level of physical exam requiring at least two bullets from each of nine organ systems.
- High Complexity Medical Decision-Making - the patient would need to have a severe exacerbation of a chronic problem or an acute illness which threatens life or bodily function to qualify for this level of risk. The data reviewed would have to be quite extensive to reach the threshold for high complexity MDM. This set of circumstances would be unusual for follow-up encounters, but may occur quite often during initial encounters.

- Abstracted from the Provider’s report titled Primary Treating Progress Note/Treatment Authorization Request: a comprehensive history, detailed exam and straight forward Medical Decision-Making.
- Based on information reviewed, reimbursement of 99214 was correct. Therefore, additional reimbursement of 99215 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99215

Date of Service: 10/29/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99214	\$210.00	\$116.38	\$93.62	1	N/A	\$116.38	DISPUTED SERVICE: No further reimbursement is recommended.

Copy to:





Copy to:



