

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 11, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000382	Date of Injury:	11/10/2008
Claim Number:	[REDACTED]	Application Received:	03/16/2015
Assignment Date:	04/14/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/05/2015 – 08/05/2015		
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 \$250.00 for the review cost and \$137.06 in additional reimbursement for a total of \$332.06. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$332.06** 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, M.D., M.P.H.  
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
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## 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 seeking remuneration for 99214 Established Patient, and WC002 PR-2 report for date of service 08/05/2015.
- Claims Administrator denied the services based on the following rationale: “Not Authorized.”
- PR-2 indicates the Provider is the Primary Treating Physician.
- EOR’s do not indicate body parts in dispute, only service as ‘Not Authorized.’
- Authorization not indicated for a Primary Treating Physician and a current Injured Worker.
- Retroactive authorization, dated 9/12/2014, reflects medications requested by Provider on previous visit as “authorized” by MD. Reviewer.
- Physician Reviewer indicated on aforementioned retroactive authorization, previously reviewed PR-2 reports from Provider as: 09/05/2014, **08/05/2014**, and 06/26/2014. The date of “06/26/2014” indicates the Provider has previously treated the Injured Worker and provided a Primary Treating Physician Progress Report (PR-2), which was reviewed and accepted by the Physician Reviewer for the Claims Administrator.
- The determination of an Evaluation and Management service for Established Patients require **two** of **three** key components in the following areas:
  - 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**

- i. History 3 Chronic Conditions or Greater than 4 elements relating to: quality, location, duration, severity, ,timing, context modifying factors, & associated symptoms
- ii. **Detailed Exam** (Extended exam of 2 – 7 affected body areas/organ systems and other symptomatic or related organ systems)
- iii. **Moderate** Complexity
  - Pertinent PMFSH related to the patient's problems.
  - 99215 Comprehensive: extended HPI, ROS that is directly related to the problems identified in the HPI plus all additional body systems, and a complete PMFSH.
- **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.**

Additional Evaluation and Management information can be found in the AMA CPT Code book or on-line at CMS.Gov.

- Abstracted information for date of service 08/5/2014 resulted in a **99214** Established Patient Evaluation and Management service:
  - **History** = Expanded Problem Focused
  - **Exam** = Detailed
  - **Medical Decision Making** = Moderate
- DWC states, “The purpose of the 45-day rule in California Code of Regulations, Title 8, section 9785(f)(8) is to make sure that in the case of continuing treatment, that the patient’s progress is monitored no less than once every 45 days.” However, “Within a 45-day period, the primary treating physician can bill for as many PR-2’s as are medically necessary.”
- PR-2 report 08/05/2014 reflects the visit was medically necessary. As such, WC002 is a reimbursable report.
- Based on the aforementioned documentation and guidelines, reimbursement is warranted for 99214 and WC002.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99214 and WC002**

<b>Date of Service:</b> 08/05/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99214	\$162.68	\$0.00	\$162.68	N/A	1	\$125.15	OMFS
WC002	\$15.48	\$0.00	\$15.48	N/A	1	\$11.91	OMFS

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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