

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 16, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000445	Date of Injury:	09/08/2014
Claim Number:	[Redacted]	Application Received:	03/27/2015
Claims Administrator:	[Redacted]		
Date Assigned:	4/24/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204, 99354 & 72070		

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 \$142.97 in additional reimbursement for a total of \$337.97. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$337.97 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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other:

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 codes 99204, 99354 & 72070
- Claims Administrator down-coded 99204 to a 99203 indicating on the Explanation of Review “The billed service does not meet the requirements of a consultation”
- 99204 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- The 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 and a complete PFSH. Provider's Initial Evaluation submitted does not document all components necessary to qualify for a comprehensive history. As 99204 requires all three components, reimbursement for a 99204 is not warranted.
- Provider billed code 99354 - Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)

- Provider documents time spent in evaluation: one and one half (1.5) hours. Reimbursement of 99354 is warranted based on documentation to support billed code.
- Provider also billed code 72070 - X-RAY EXAM THORAC SPINE 2VWS
- Documentation submitted states two x rays of thoracic spine – AP and Lateral views. Reimbursement of 72070 is warranted as documentation does support code billed.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99354 and 72070 is recommended.

Date of Service: 11/12/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99354	\$114.35	\$0.00	\$114.35	1	N/A	\$114.35	Allow reimbursement \$114.35
72070	\$57.23	\$0.00	\$57.23	1	N/A	\$28.62	Allow reimbursement \$28.62

Copy to:

██████████
 ██████████
 ██████████

Copy to:

██
 ██
 ████████████████████████████████████