

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 17, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000971	Date of Injury:	12/08/2014
Claim Number:	[Redacted]	Application Received:	06/15/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/03/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204		

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 \$57.71 in additional reimbursement for a total of \$252.71. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$252.71 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 99204
- Claims Administrator down coded 99204 to 99203 indicating on the explanation of Review “Level of E&M code submitted is not supported by Documentation”
- 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.
- §9789.12.11. Evaluation and Management: Coding - New Patient; Documentation: (b) To properly document and determine the appropriate level of evaluation and management service, physicians and qualified non-physician practitioners must use either one of the following guidelines but not a combination of the two guidelines for a patient encounter. If the physician's or qualified non-physician practitioner's documentation for a medically necessary service conforms to either one of the guidelines, the maximum reasonable fee shall be according to the documented level of service: (1) The “1995 Documentation Guidelines for Evaluation & Management Services,” or (2) The “1997 Documentation Guidelines for Evaluation and Management Services.”
- Based on 1995 Guidelines, Provider’s report submitted documents a comprehensive history a comprehensive examination and Medical decision making of moderate complexity. Therefore, reimbursement of 99204 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99204

Date of Service: 03/03/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99204	\$300.00	\$133.40	\$166.60	1	N/A	\$191.11	DISPUTED SERVICE: Allow reimbursement \$57.71

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