

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 17, 2016

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000614	Date of Injury:	05/06/2014
Claim Number:	[Redacted]	Application Received:	04/14/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	8/26/2015, 10/26/2015 & 12/15/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	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: 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 \$73.30 in additional reimbursement for a total of \$268.30. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$268.30 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: N/A
- 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 seeking remuneration for CPT code 99214 on two dates of service 10/26/2015 & 12/15/2015
- Claims Administrator down coded 99214 to 99213 on both dates of service with rationale “assigned procedure code better describes the services performed based on the reviewed description of the service and supporting documentation”
- The determination of an Evaluation and Management service for Established Patients require two of three key components in the following areas (1995/1997 CMS Guidelines):
 - 1) History: Chief Complaint, History of Present Illness, Review of Systems (Inventory of Body Systems), Past Family and Social History.
 - 2) Examination: Problem Focused, Expanded Problem Focused, Detailed Comprehensive “(General multi-system examination, or complete examination of a single organ system or other symptomatic related body area(s) or organ system(s).”
 - 3) Medical Decision Making Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:
 - a) The number of possible diagnoses and/or the number of management options that must be considered;

- b) The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
 - c) The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options.
- 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
- Provider's Primary Treating Progress Report submitted documents a detailed history, problem focused exam and moderate complexity Medical Decision Making = 2 of 3 Meet or Exceed = 99214
- EORs received shows a 15% PPO discount is to be applied to reimbursement.
- Based on documentation and guidelines additional reimbursement of 99214 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99214

Date of Service: 10/26/2015 & 12/15/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99214	\$160.00	\$76.34	\$47.60	2	\$112.99	\$73.30 Due to Provider

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