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## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 31, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000754	Date of Injury:	05/24/2014
Claim Number:	[REDACTED]	Application Received:	05/05/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/04/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99214-24		

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,

Maximus

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
- OMFS

## 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 – 24 Evaluation and Management services performed on 02/04/2016.**
- The Claims Administrator denied services due to “the visit or service billed, occurred within the global surgical period and is not separately reimbursable.”
- Provider billed code 99214-24 along with 99024, Post Op follow up, on a CMS 1500. Four diagnoses codes were submitted on the claim form and Diagnosis Pointer:
  - A. S33.5XXA Sprain of ligaments of lumbar spine, initial encounter
  - B. S16.1XXA Strain of muscle, fascia and tendon at neck level, initial encounter
  - C. G56.02 Carpal tunnel syndrome, left upper limb
  - D. Z98.89 Other specified post procedural states
- Both CPT codes 99214 and 99024 have Diagnosis Pointers at all four diagnosis: “ABCD”
- Contractual Agreement Not submitted for IBR.
- Only one report submitted for review, Provider’s PR-2 report suggests: “Chief Complaints: Neck, mid back and low back, and bilateral wrist pain. Subjective Complaint: The patient returns today for follow-up with persistent pain in the neck at 2-3/10, mid and low back at 6/10 and worsening. It is radiating down into his left leg and into his calf. Bilateral wrist pain is at 3/10. He denies pain in the knees and right ankle and foot.”
- EOR’s and PR-2 indicate wrist as the accepted body part. **Documentation supporting additional accepted body parts/injuries not submitted for IBR.**

- Wrist follow up falls within surgical global period.
- **Based on the aforementioned documentation and guidelines, reimbursement for 99214-24 is not indicated.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: CPT 99214-24**

<b>Date of Service:</b> 02/04/2016						
<b>Physician Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99214-24	\$181.43	\$0.00	\$181.43	1	\$0.00	<b>Refer to Analysis</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]