

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280

8/30/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/22/2013 – 1/22/2013
MAXIMUS IBR Case: CB13-0000133

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 7/2/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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
- Other: OMFS and AMA CPT Evaluation and Management Coding Guidelines

Supporting Analysis:

The dispute regards the amount paid for Evaluation and Management services for date of service 1/22/2013. The Provider billed CPT 99214 Modifier 93, was reimbursed \$57.61 and is requesting additional reimbursement of \$40.92. The Claims Administrator down coded the billed code CPT 99214 to CPT 99213 indicating "Based on attached documentation, history is expanded, examination is expanded and medical decision making appears to be of low complexity. In this instance, procedure 99213 appears more appropriate."

The description of CPT 99214 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity." The description of CPT 99213 is " Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity."

Detailed history is defined as meeting the requirements of or documenting the chief complaint, an extended history of present illness and a problem pertinent system review. The history documented did not meet the requirements of a detailed history as defined by the AMA CPT Evaluation and Management Guidelines. The medical record only documented three elements of history of present illness: location, duration and quality. The review of systems (ROS) was directly related to the chief complaint.

Detailed examination is defined as an extended examination of the affected body area(s) and other symptomatic or related organ system(s). The extent of the examination did not meet the requirements of a detailed examination as defined by the AMA CPT Evaluation and Management Guidelines. The documentation demonstrated a limited examination of the affected body area. The complexity of medical decision making appears to be of low complexity due to the limited number of diagnoses, data review and low risk of complications. The Provider prescribed medications and recommended range of motion and muscle testing, x-ray, MRI, hinged knee support and a cane.

The documentation submitted does not support reimbursement of CPT 99214. The Claims Administrator's code assignment and reimbursement of 99213 was appropriate. There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99213 Modifier 93.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99213	93		1	\$40.92	\$57.61	\$57.61	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on AMA CPT Evaluation and Management Coding Guidelines and comparison with PPO Contract. This was determined correctly by the Claims Administrator and the payment of \$57.61 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[REDACTED] RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

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