

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280

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6/10/2013

**Independent Bill Review Final Determination**

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: January 2, 2013  
MAXIMUS IBR Case: CB13-0000011

Dear [REDACTED], MD:

**Determination**

A Request for Independent Bill Review (IBR) pursuant to California Labor Code section 4603.6 was received by MAXIMUS Federal Services on 4/11/2013. The Administrative Director of the California Division of Workers' Compensation assigned MAXIMUS Federal Services, Inc. to perform the Independent Bill Review, pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **plan determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing.**

**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
- Official Medical Fee Schedule
- Other: Mediregs Audit and Revenue Resource Center Coding Definitions, AMA CPT 2013 Evaluation and Management Services Guidelines

### Supporting Analysis:

The decision to overturn the final determination made by Intercare to downcode the Evaluation and Management CPT code 99214 to CPT code 99213 was based on the AMA CPT Evaluation and Management Services Guidelines. The requirements and description of CPT 99214 is an office or other outpatient visit for the evaluation and management of an established patient which requires at least 2 of these 3 required components: A detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problems are of moderate to high severity. Typically, 25 minutes are spent face to face with the patient and/or the family.

Under the Division of Workers' Compensation Official Medical Fee Schedule guidelines, Division of Workers' Compensation follows the AMA Physician's CPT Evaluation and Management coding guidelines 1997 version.

The appropriateness on the reported level of the CPT E/M 99214 is clearly documented within the primary treating physician's progress report (PR-2).

Based on the medical documentation submitted, the provider demonstrated that their Evaluation and Management of the patient met 2 of the 3 required components which are a detailed examination and medical decision making of moderate complexity.

The detailed examination criteria was met based on the review of the following body areas; 1. Lumbar Spine and surgical site, discussion of bowel and bladder incontinence, sensation and reflexes of lower extremities, hips and gait. The patient's presenting problems are moderate to severe in complexity.

The medical decision making of moderate complexity criteria was met based upon the documentation of the following medical issues; multiple diagnosis, discussion of multiple management options which included, physical therapy, chiropractic services, acupuncture, injections and an in depth conversation at length in regards to the TFESI procedure bilaterally for diagnostic and therapeutic purposes. Discussion of continuation of home exercise and medication management and the alternatives, side effects and potential complications as well as the review of the MRI results. The additional reimbursement of \$38.33 for Official Medical Fee Schedule code 99214 is warranted based on the following calculation:

OMFS fee schedule allowance is \$89.57. Claims Administrator paid \$51.24. The difference between the amount allowed and paid is \$38.33

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
99214			1	\$38.33	\$89.57	\$51.24	\$38.33	OMFS
				\$ .	\$ .	\$ .	\$ .	
				\$ .	\$ .	\$ .	\$ .	
				\$ .	\$ .	\$ .	\$ .	
				\$ .	\$ .	\$ .	\$ .	

As this determination finds that the Claims Administrator owes the provider additional reimbursement, the Claims Administrator is required to reimburse the provider for the IBR application fee **(\$335.00)** in addition to the amount rewarded within **45 days of date on this notice per section 4603.2 (2a)**.

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,

██████████, RHIT

Copy to:

██████████  
██████████  
██████████

Copy to:

Division of Workers' Compensation Medical Unit

██████████  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612