

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280

7/30/2013

Independent Bill Review Final Determination Reversed

[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/21/2013 – 1/21/2013
MAXIMUS IBR Case: CB13-0000048

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 5/31/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$10.25, for a total of \$345.25.**

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 or negotiated contract: OMFS
- Other: AMA CPT Evaluation and Management Guidelines and OMFS Evaluation and Management Modifiers

Supporting Analysis:

The dispute regards the amount paid for Evaluation and Management services on date of service 1/21/2013. The provider billed CPT 99214 Modifier 93, was reimbursed \$52.38 and is now requesting an additional payment of \$46.15. The Claims Administrator downcoded the billed code to 99213 and indicated " Based on the attached documentation, the history is expanded, the examination is expanded and the 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 two of these three key components: detailed history, detailed examination or medical decision making of moderate complexity." The description of Modifier 93 is "Interpreter required at the time of the examination." The description of CPT 99213 is "Office visit or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: expanded problem focused history, expanded problem focused examination or medical decision making of low complexity."

Based on the review of the documents submitted, the provider did not demonstrate that the Evaluation and Management services met the two of the three required components of CPT 99214. The documentation submitted met the criteria described in CPT 99213. The Provider documented an expanded problem focused history, expanded problem focused exam with medical decision making of low complexity.

Expanded problem focused history is defined as meeting the requirements of or documenting the chief complaint, a brief history of present illness and a problem pertinent system review. The patient's chief complaint was documented, location of pain, associated signs and symptoms of illness were discussed as well as a review of the body area directly related to the chief complaint.

Expanded problem focused history is defined as a limited examination of the affected body area or organ system and other symptomatic related organ system(s). The provider documented a review of two organ system: musculoskeletal and psychiatric. 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 code assignment of CPT 99213 by the Claims Administrator was appropriate. However, the payment by the Claims Administrator was incorrect. The Claims Administrator did not pay for the additional allowance for the use of an interpreter. Per the OMFS guidelines, Modifier 93 may be appended to an Evaluation and Management code when appropriate. The report stated the use of an interpreter and the Provider appended modifier 93 to the billed E&M code.

MAXIMUS requested the PPO contract used in the original calculation of payment. The PPO contract was not received therefore; payment calculation is based on the OMFS schedule. The additional reimbursement of \$10.25 is warranted based on the following calculation.

OMFS CPT 99213 \$56.93

OMFS Modifier 93 The value of the procedure is modified by multiplying the normal value by 1.1.

$\$56.93 \times 1.1 = 62.63$

$\$62.63 - 52.38$ (previously paid by Claims Administrator) = \$10.25

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	\$46.15	\$62.63	\$52.38	\$10.25	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT 99213 Modifier 93 ($\$62.63 - 52.38 = 10.25$) for a total of \$345.25.

The Claims Administrator is required to reimburse the provider \$345.25 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
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