

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 10, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000993	Date of Injury:	06/02/2000
Claim Number:	[REDACTED]	Application Received:	12/30/2013
Claims Administrator:	[REDACTED]	Assignment Date:	10/06/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215		

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 \$335.00 for the review cost and \$85.09 in additional reimbursement for a total of \$420.09. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$420.09 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,

[REDACTED]
Chief Coding Reviewer

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: [REDACTED]
- National Correct Coding Initiatives
- Other: CMS 1997 Documentation Guidelines for Evaluation and Management Services, CPT published by AMA

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:** Office Visit 99215-25 denied for same day of surgery or within the follow up of a previously billed surgery.
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT were reviewed.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99214. No evidence of a previously billed surgery by [REDACTED] that fell within the global period was identified. This visit was a scheduled medication management visit.
- Based on the PR-2 submitted for service date 02/08/2013 the disputed E/M Level 99215-25 is not supported in the chart note. The presenting complaint was for medication management and for treatment authorizations. The medical decision making does not meet a HIGH level as found in 99215. Evaluation and management of multiple issues and prescription management satisfies Moderate decision making. The patient was “doing well” and was advised to “continue with conservative treatment.” The History documentation did support a Comprehensive and complete History. The examination did meet a detailed exam of more than 12 bullets per 1997 CMS Coding Guidelines. Per CPT, a Level 99214 requires two of the three key components. The key components of History, Exam and Medical Decision Making fulfill the E/M level of 99214 per AMA and CMS standards.
- A 5% discount is applied per the Corvel contract.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99215-25 to be made at the level of 99214-25. An additional reimbursement of \$85.09 is to be made to the Provider.

Date of Service: 2/8/2013							
[REDACTED]							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99215-25	\$ 262.50	\$ 0	\$ 129.41	N/A	N/A	\$ 85.09	DISPUTED SERVICE: Allow reimbursement for E/M code 99214-25.

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]