

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 21, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000286	Date of Injury:	07/24/1995
Claim Number:	[Redacted]	Application Received:	03/03/2014
Claims Administrator:	[Redacted]	Assignment Date:	04/11/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99214, 99401 and 99081		

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 \$101.26 in additional reimbursement for a total of \$436.26. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$436.26 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: none included in case documents
- National Correct Coding Initiatives
- Other: CMS 1997 Documentation Guidelines for Evaluation and Management Services, 2013 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 CPT code 99214-25, 99401, 99081 denied as bundled by the claim administrator.
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT 2013 Edition was reviewed.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99214-25.
- Based on the PR-2 and Primary Treating Physicians Progress Reports for service date 10/24/2013 the disputed E/M Level 99214-25 is supported in the chart note. The patient received an electronic analysis for his implantable pump at the same visit. The presenting complaint was for “reevaluation of knee and back pain.” During the course of the visit the physician elected to perform an electronic analysis of the patient’s implanted pump, code 62368. The documentation supports a “significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure.” The physician documented multiple treatment options with a detailed history and detailed examination of the patient separate from the analysis of the implanted pump.

The office visit, 99214, was correctly submitted with modifier 25 to delineate these two services. CPT code, 62368, does not have a global concept.

- Code 99081 allowed per the General Information section of the OMFS.
- Deny CPT code 99401. Per the OMFS “These codes are used to report services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury. This was not a separate encounter therefore the service was appropriately denied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Allow additional reimbursement of \$101.26 for CPT codes 99214 and 99081.

Date of Service: 10/24/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99214-25	\$225.00	\$0.00	\$ 125.06	N/A	N/A	\$89.57	DISPUTED SERVICE: Allow Reimbursement of \$89.57.
99081	\$75.00	\$0.00	Included in above	N/A	N/A	\$11.69	DISPUTED SERVICE: Allow reimbursement of \$11.69.
99401	\$25.00	\$0.00	Included in above	N/A	N/A	\$0.00	DISPUTED SERVICE: Deny as not a separate encounter.

Copy to:

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