

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



---

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 1, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001435	<b>Date of Injury:</b>	03/01/2007
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	09/26/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	10/22/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	99214-25 and 62368		

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 \$250.00 for the review cost and \$116.24 in additional reimbursement for a total of \$366.24. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$366.24 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]

Medical Director

cc: Joan Ashick, Gallagher Bassett  
Division of Workers’ Compensation (DWC) Medical Unit

## 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
- National Correct Coding Initiatives
- Other: OMFS Physician Services

## 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:** Provider is dissatisfied with denial of CPT cods 99214-25 and 62368.
- Claims Administrator denied claim and indicated on Explanation of Review “This charge is denied as the service was not authorized during the utilization review process.”
- Pursuant to Title 8, §9785 Reporting Duties of the Primary Treating Physician, (g) As applicable in section 9792.9.1, a written request for authorization of medical treatment for a specific course of proposed medical treatment, or a written confirmation of an oral request for a specific course of proposed medical treatment, must be set forth on the “Request for Authorization,” DWC Form RFA, contained in section 9785.5. Authorization for an office visit is not necessary, and therefore Claims Administrator was incorrect to deny 99214-25.
- Authorization was submitted for this review. As dated May 05, 2014 by Utilization Review Nurse for retroactive dates of service 12/10/2013-07/10/2014 for 62368 x 8.
- Follow Up report submitted lacks documentation to qualify for a 99214. Modifier -25: Significant, Separately Identifiable Evaluation and Management Service by the same Physician on the Same Day of a Procedure or Other Service. Based on information reviewed, a level 3 Office Visit is recommended: Expanded Problem Focused History and Exam with Low Complexity Medical Decision-Making.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information received, reimbursement of codes 99213-25 and 62368 is warranted.**

<b>Date of Service:</b> 04/18/2014						
<b>Physician Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99213-25	\$225.00	\$0.00	\$89.53	1	\$ 58.28	<b>DISPUTED SERVICE:</b> Allow reimbursement \$58.28.
62368	\$870.00	\$0.00	\$57.96	1	\$ 57.96	<b>DISPUTED SERVICE:</b> Allow reimbursement \$57.96

Copy to:

██████████  
██████████  
██████████  
██████████

Copy to:

██  
████████████████████████████████████  
████████████████████████████████