

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 30, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001482	<b>Date of Injury:</b>	04/04/2009
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	10/03/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	11/05/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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: [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:
- National Correct Coding Initiatives

## 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 reimbursement and down-coding of CPT 99215. Provider billed code 99215 and was reimbursed for code 99213.
- Claims Administrator down-coded 99215 to 99213 indicating on the Explanation of Review “The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.”
- CPT 99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of high complexity.
- Provider submitted a Primary Treating Physician’s Progress Report (PR-2) which does not document the components needed to qualify for a 99215. Provider documents in the PR-2 “Total time – 42 minutes prolonged by use of interpreter as well as reviewing medical records in patient’s presence – billed 99215 as time requirement was met.”
- The appropriate documentation must be included in the report, time alone does not justify the Evaluation and Management code type. See Prolonged Services procedure codes.

- Based on information reviewed, Claims Administrator was correct in reimbursement of down-coding 99215. Therefore, additional reimbursement of code 99215 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 99215 is not recommended.**

Date of Service: 6/30/2014							
Physician Service							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99215	\$166.31	\$80.74	\$85.57	1	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No additional reimbursement recommended.

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