

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 6, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000623	Date of Injury:	11/11/2011
Claim Number:	[Redacted]	Application Received:	04/21/2014
Claims Administrator:	[Redacted]	Assignment Date:	06/24/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99214-93		

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 \$39.04 in additional reimbursement for a total of \$289.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$289.04 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

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 down coded to a CPT code 99213.
- The CMS 1997 Guidelines were reviewed.
- Based on review of the medical record documentation the services rendered satisfied the requirements for CPT code 99214.
- Based on the PR-2 for office visit 11/15/2013, the disputed E/M Level of 99214-93 is supported in the chart note. The patient's history was detailed including four history of present illness elements, 2 pertinent review of systems and a pertinent social history. The examination documentation utilized the 1997 E/M guidelines which require 12 or more bullets in the musculoskeletal specialty exam. This examination included 10 bullets which fulfills an expanded problem focused examination. Medical decision making is based on number of diagnoses managed at this visit, the risk to the patient and if the conditions are stable or have inadequate response. The patient had worsening conditions in both back and legs. Physician reviewed old medical records and summarized the reports, ordered prescription management, and documented need for surgical interventions. The use of an interpreter was medically necessary and documented. Per CPT, a Level 99214 requires two of the three key components. The key components of history and medical decision fulfill the E/M level of 99214 per CMS standards.
- Additional reimbursement permitted for use of an interpreter.

- Reimbursement calculation: $89.57 * 1.1 = \$98.53$

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99214-93 to be allowed.

Date of Service: 11/15/2013							
Physician: [REDACTED]							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99214-93	\$ 225.00	\$ 59.49	\$ 165.51	n/a	n/a	\$98.53	DISPUTED SERVICE: Allow additional reimbursement of \$39.04.

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