

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 6, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000858	Date of Injury:	07/03/2010
Claim Number:	[Redacted]	Application Received:	06/13/2014
Claims Administrator:	[Redacted]		
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.

IBR Assigned: 07/15/2014

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 \$44.51 in additional reimbursement for a total of \$294.51.

A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$294.51 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
- National Correct Coding Initiatives
- Other: Evaluation and Management Guidelines

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 the reimbursement of CPT 99215. When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services.
- The Provider submitted a Primary Treating Physician's Progress Report (PR-2) for date of service 01/07/2014.
- The decision making and presenting problems were of moderate complexity and the medical record noted time spent with worker was over 1 hour, with over half the time was spent with counseling the patient.
- The report documented a lengthy discussion with the worker in subjective portion of the medical record.
- CPT 99215: Typically, 40 minutes are spent face-to-face with the patient and/or family.
- The supplied medical record supports the use of code 99215.
- Formula: $\text{Work RVU} * * \text{Statewide Work GAF} + (\text{Non-Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF}] * \text{Conversion Factor (CF)} = \text{Base Maximum Fee}$
- $(2.11 * 1.040) + (1.79 * 1.1606) + (.13 * .6636) * 38.3542 = 167.15$

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99215

Date of Service: 1/7/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99215	\$167.15	\$122.64	\$44.51	N/A	1	\$167.15	DISPUTED SERVICE: Additional reimbursement of \$44.51.

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