

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 11, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000890	Date of Injury:	11/07/2012
Claim Number:	[REDACTED]	Application Received:	06/23/2014
Claims Administrator:	[REDACTED]	Assignment Date:	07/28/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	WC007 and 99203-93		

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: 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
- AMA CPT 2014

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 seeking remuneration for 99203-93 and WC007 services performed on 02/25/2014.**
- Claims Administrator reimbursement rationale: “99203 changed to: 99213 Better Defining Services Performed.”
- **WC007** – California Specific Service Indicator - Modifier required to specify type of service.
- Documentation dated 01/31/2014 from Claims Administrator reveals authorization for WC007 services and authorized charges; no referenced appointment date.
- Submitted WC007 on CMS 1500 form dated 02/26/2014; does not reflect authorized charge indicated on authorization.
- 2014 OMFS requires Modifier indicating type of WC007 service.
- Submitted WC007 on CMS 1500 form dated 02/26/2014; does not indicate modifier appended to service.
- **99203 Code Description:** Office or other outpatient visit for the evaluation and management of a **new patient**, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity, counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and

the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity, typically, 30 minutes are spent face-to-face with the patient and/or family. (AMA CPT 2014)

- **New vs. Established Patient:** An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, **within the past three years.** (AMA CPT 2014)
- Page 2 of the consultation report, paragraph 2, the Provider states; "... since I evaluated him on June 4, 2013..."
- Documentation does not meet the criteria for 99203 new patient services.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 99203-93 and WC007 is not recommended.

Date of Service: 02/25/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99203-93	\$245.00	\$84.99	\$160.01	N/A	1	\$84.99	Provider Reimbursed OMFS
WC007	\$192.50	\$0.00	\$192.50	N/A	1	\$0.00	Refer to Analysis

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