

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 9, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001540	Date of Injury:	08/27/2012
Claim Number:	[REDACTED]	Application Received:	10/14/2014
Claims Administrator:	[REDACTED]	Assignment Date:	11/24/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215 and 99080		

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
- Other: 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 is dissatisfied with reimbursement of down-coded CPT 99215 to 99213 and denial of 99080.
- Claims Administrator down-coded 99215 and reimbursed Provider based on CPT 99213 indicating on the Explanation of Review “The billed service does not meet the requirements of a consultation”
- 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 document containing only the provider’s letterhead, which states “This is NOT a PR-2 report but a request for treatment and special report as the patient’s condition has taken a significant step for the worse.”
- Provider’s letter does not fulfill the requirements for a 99215 as there is not a comprehensive history or examination.
- Based on information reviewed, Claims Administrator was correct to down-code 99215 to 99213 and therefore, no additional reimbursement is warranted

- Provider billed code 99080, Special Report. The documentation contained in the letter submitted would be found in the Primary Treating Physician’s Progress Report (PR-2). Under the General Information and Instructions Report section: “Primary Treating Physician’s Progress Reports, reported in accordance with Title 8, California Code of Regulation Section 9785 (f), using DWC Form PR-2 or its equivalent, when (1) the employee’s condition undergoes a previously unexpected significant change;” Provider states at the beginning of his special report submitted that it is not a PR-2 and is not on the official form to be reimbursed as such.
- Provider’s letter submitted to IBR states “This report was generated at the request of the claims examiner and should be paid in accordance to OMFS for a three page report at \$123.25”. However, there is no formal request from the claims examiner submitted for this review.
- Based on information reviewed on 99080, reimbursement is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99215 and 99080 is not recommended.

Date of Service: 05/10/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99215	\$169.00	\$56.93	\$112.07	1	N/A	\$56.93	DISPUTED SERVICE: No reimbursement is recommended.
99080	\$123.25	\$0.00	\$123.25	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement is recommended.

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