

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 3, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001671	Date of Injury:	03/07/2014
Claim Number:	[Redacted]	Application Received:	11/03/2014
Claims Administrator:	[Redacted]	Assignment Date:	12/10/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99214-25		

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,

Paul Manchester, M.D., M.P.H.
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

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 99214 Evaluation and Management Services provided on 07/17/2014.**
- The Claims Administrator denied the service with the following rationale: “No separate payment was made because the value of the services is included within the value of another services performed on the same day.”
- Title 8, California Code of Regulations Section 8 CCR § 9789.11(a)(l), Physical Medicine General Information and Ground Rules, Page 503A(f) : “The reimbursement for follow up evaluation and management services for the routine reassessment of an established patient is included in the value of the treatment codes in the Physical Medicine Section of the schedule. Follow-up Evaluation and Management services for the re-examination of an established patient may be reimbursed in addition to physical medicine, manipulation, starred procedures and acupuncture only when any of the following applies:
 - The patient fails to respond to treatment requiring a change in treatment plan
 - The patient fails to respond to treatment requiring a change in the treatment plan
 - It is medically necessary to provide evaluation services over and above those normally provided during the therapeutic services and included in the reimbursement for physical medicine treatment (Documentation may be required).
 - It is necessary to provide evaluation services to meet the reporting requirements set forth in Title 8; California Code of Regulations Section 9785(c).
 - §9785 (c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. A claims administrator may designate any person or entity to be the recipient of its copy of the required report
- Provider is treating Injured Worker secondary to Primary Physician.

- Documentation reflects Injured Worker was seen for a follow-up visit in addition to Chiropractic Procedures.
- Six weeks of additional Chiropractic treatment has been ordered by the Primary Physician.
- Documentation does not fall within the guidelines indicated under “General Information and Instructions.”

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement for code 99214-25 is not warranted.

Date of Service: 07/17/2014							
Provider Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99214	\$125.14	\$0.00	\$125.14	N/A	1	\$0.00	Refer to Analysis

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