

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 23, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001692	Date of Injury:	05/10/2011
Claim Number:	[REDACTED]	Application Received:	11/11/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/09/2014 – 07/09/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215 and WC002		

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 \$11.91 in additional reimbursement for a total of \$261.91. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$261.91 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]
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

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 codes 99215 and WC002
- Claims administrator down-coded Provider's billed CPT 99215 to 99213 indicating on the Explanation of Review "Based on the attached documentation, the history is expanded, the examination is expanded and the medical decision-making appears to be of low complexity. In this instance, procedure 99213; appear more appropriate." Based on the PR-2 submitted, claims administrator was correct to down-code to a 99213 and therefore additional reimbursement is not warranted for CPT 99215.
- Claims administrator denied code WC002 indicating on the Explanation of Review "Regarding WC002, the submitted documentation does not meet the criteria listed in the PFS. Pre 2014 Refer to the General Rules. Post 01/01/2014, refer to CCR 9789.14. Referral/auth. was request on the last PR2 report on 6-6-14."
- Provider states he has requested authorization for physical therapy and for lab testing which has not been submitted by claims administrator. Due to information reviewed, reimbursement of WC002 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code WC002 is recommended.

Date of Service: 7/9/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99215	\$166.31	\$76.49	\$89.82	1	N/A	\$76.49	DISPUTED SERVICE: No reimbursement recommended.
WC002	\$11.91	\$0.00	\$11.91	1	N/A	\$11.91	DISPUTED SERVICE: Allow reimbursement \$11.91

Copy to:

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