
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 11, 2015

[REDACTED]
[REDACTED]
[REDACTED]

| | | | |
|------------------------------|--------------|------------------------------|------------|
| IBR Case Number: | CB14-0001716 | Date of Injury: | 02/22/2013 |
| Claim Number: | [REDACTED] | Application Received: | 11/14/2014 |
| Claims Administrator: | [REDACTED] | Assignment Date: | 12/16/2014 |
| Provider Name: | [REDACTED] | | |
| Employee Name: | [REDACTED] | | |
| Disputed Codes: | 99214 | | |

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]
Division of Workers’ Compensation (DWC) Medical Unit

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 submitted to Claims Administrator for date of service 04/24/2014.**
- The Claims Administrator denied the service with the following rational: “The visit or service billed, occurred within the global surgical procedure, or within the 90 day follow up period.”
- PR-2 documentation reflects a “follow-up” visit for pain of the lumbar spine and notes Injured Worker presents status post 04/04/14 L5-S1 micro-discectomy.
- Provider is an Orthopedic Surgeon in a Group Practice with the Orthopedic Surgeon who performed the 04/04/14 L5-S1 micro-discectomy.
- Unless specifically stated in a Contractual Agreement for a Group Practice, Surgical Packages are paid to the Group, and not to an Individual Practitioner/Surgeon.
- The Contractual Agreement is not available for IBR.
- If an Evaluation and Management services is performed in a group setting during a global period and the reason for the visit is not related to the surgical procedure, then Modifier -24 “Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period” is appended to the appropriate level of service.
- The CMS 1500 does not reflect a modifier.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214

| Date of Service: 04/24/2014 | | | | | | | |
|------------------------------------|------------------------|---------------------|-----------------------|-----------------------|--------------|-----------------------------------|--------------------------|
| Provider Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Units | Workers' Comp Allowed Amt. | Notes |
| 99214 | \$162.68 | \$0.00 | \$162.68 | N/A | 1 | \$0.00 | Refer to Analysis |

Copy to:

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Copy to:

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