



## 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 denial of codes 99214 and WC002.
- Claims administrator denied codes indicating on the Explanation of Review “
- Evaluation and Management visits by the treating physician do not require prior authorization and claims administrator was incorrect to deny the office visit. WC002 is a report required by the treating physician every 45 days from the last report and is warranted reimbursement as well.
- Provider billed a 99214 - 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 detailed history; A detailed examination; Medical decision making of moderate complexity.
- The Primary Treating Physician Progress Report received, provider shows documentation for a Detailed History and a Moderate Complexity Medical Decision Making which satisfies the requirements for an E&M visit of 99214.
- Based on information reviewed, reimbursement of 99214 and WC002 is warranted.
- Maximus does not review penalties and interest pre provider’s request.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99214 and WC002 is recommended.

<b>Date of Service:</b> 5/20/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99214	\$162.68	\$0.00	\$162.68	1	N/A	\$125.14	<b>DISPUTED SERVICE:</b> Allow reimbursement \$125.14
WC002	\$15.48	\$0.00	\$15.48	1	N/A	\$11.91	<b>DISPUTED SERVICE:</b> Allow reimbursement \$11.91

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]