

**MAXIMUS FEDERAL SERVICES, INC.**

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

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 10, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB15-0000054	<b>Date of Injury:</b>	09/10/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	01/14/2015
<b>Claims Administrator:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	99215-17		

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 \$195.00 for the review cost and \$37.34 in additional reimbursement for a total of \$232.34. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$232.34 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,

Paul Manchester, MD  
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
- National Correct Coding Initiatives
- Other: OMFS Physicians Fee Schedule

## 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: Office Visit 99215 down coded to a 99213 by Claim Administrator.**
- The CMS 1997 Guidelines and the American Medical Association (AMA), CPT 2014 Edition were reviewed.
- Based on review of the medical record documentation the services rendered satisfy the requirements for CPT code 99214 not 99215 as originally submitted.
- The Medical Report documentation for date of service 9/29/14 included History elements that satisfy the Comprehensive level.
- The examination performed was a Problem Focused examination of the upper extremities (wrist and thumb). The requirements for a Comprehensive Exam for a 99215 require 29 elements to be documented. See below regarding the MSK portion required per CMS 1997 Coding Guidelines:
  - *For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.*
- The examination was Problem Focused based on the 1997 E/M Coding Guidelines for a Musculoskeletal Examination.
- Medical Decision Making was Moderate based on a condition, interpretation of MRI and decision making in regards to work status and future treatment. The visit did not appear to be a HIGH level of decision making (99215). High level Decision Making would include “one or more chronic conditions with severe exacerbation, progression or side effects of treatment, or an injury that may pose a threat to life or bodily function.”
- Per CPT 2014, this office visit meets two of the three key components necessary (Detailed History & Moderate Medical Decision Making) for a Level 99214.
- Reimbursement recommended for CPT 99214.
- PPO Contract indicates a 7% Discount to be applied.

