

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 22, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000072	Date of Injury:	11/01/2011
Claim Number:	[Redacted]	Application Received:	01/20/2015
Claims Administrator:	[Redacted]		
Assigned Date:	2/24/2015		
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, MD, MPH  
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

## 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 code 99214
- Claims administrator down coded 99214 to 99213 indicating on the Explanation of Review “the billed service does not meet the requirements of a consultation.”
- **99214: Detailed History / Detailed Exam / Moderate Complexity**
  - i. History 3 Chronic Conditions or Greater than 4 elements relating to: quality,location,duration,severity, ,timing, context modifying factors, & associated symptoms
  - ii. **Detailed Exam** (Extended exam of 2 – 7 affected body areas/organ systems and other symptomatic or related organ systems)
  - iii. **Moderate Complexity**
- **Time:** In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services. The total length of time of the encounter (faced-to-face) should be documented and **the record should describe the counseling and/or activities to coordinate care.**
- Two Hand Written Patient Encounter Forms. 1) Progress note, “N° 83060,” under the heading, “Medication,” there appears to be entry of “45 min” documented (hand writing not clear). However, there is no description indicting what portion of the visit was spent on “counseling and/or activities to coordinate care (AMA CPT),” or if the entry is in fact, in relation to the total time of the visit. The documentation does not clarify what the indicated time, ‘45’ min, is in relation to. Important notation, the progress note does not

reflect the Provider's name or Practice and is not signed by the Provider. 2) PR-2 form; documentation appears to be a formal representation of handwritten progress note 'N° 83060'. The 45 min time is documented on the PR-2 but does not meet the documentation requirements for time driven patient encounters. IBR unable to clarify what portion of the indicated time related to the exam and what portion of the time related to counseling or coordination of care.

- Based on information reviewed, additional reimbursement of 99214 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 99214 is not recommended.

<b>Date of Service:</b> 10/23/2014							
<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	\$126.00	\$84.99	\$40.15	1	N/A	\$84.99	<b>DISPUTED SERVICE:</b> No reimbursement recommended.

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