

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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 23, 2015

[REDACTED]
[REDACTED]
[REDACTED]

| | | | |
|-----------------------|-------------------------|-----------------------|------------|
| IBR Case Number: | CB15-0001723 | Date of Injury: | 06/17/2013 |
| Claim Number: | [REDACTED] | Application Received: | 09/25/2015 |
| Claims Administrator: | [REDACTED] | | |
| Date(s) of service: | 05/28/2015 | | |
| Provider Name: | [REDACTED] | | |
| Employee Name: | [REDACTED] | | |
| Disputed Codes: | 99215, E0191, and L3999 | | |

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 \$34.21 in additional reimbursement for a total of \$229.21. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$229.21 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
- PPO Contract Discount 5%

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 and denial of codes E0191 and L3999.**
- Provider's IBR application documents "1st visit with provider. Met criteria 2 or 3 components for CPT 99213, exceeds CPT 99213" and in Provider Type checked "Other Practitioner – specify: 2nd Opinion Referral"
- Provider billed code 99215 - Office or other outpatient visit for the evaluation and management of an **established patient**.
- Title 8, California Code of Regulations: In the office or other outpatient setting where a consultation / evaluation is performed, physicians and qualified non-physician practitioners shall use the CPT visit codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a **new or established patient to that physician**, as defined in section 9789.12.11.
- Provider's report submitted for review indicates "DJM Initial Evaluation"
- As date of service 5/28/2015 was a new patient visit then Provider failed to bill the correct Evaluation and Management code.
- Reimbursement for 99215 is not warranted.
- Claims Administrator denied codes E0191 and L3999.
- E0191- Protector heel or elbow; L3999- Upper limb orthosis nos
- Provider's report documents E0191 and L3999 for date of service 5/28/2015.
- Reimbursement is warranted for E0191 and L3999.
- PPO Contract indicates a 5% Discount to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes: E0191 and L3999.

| Date of Service: 05/28/20105 | | | | | | |
|-------------------------------------|------------------------|---------------------|-----------------------|--------------|-----------------------------------|--|
| Physician Services | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes |
| 99215-17 | \$240.00 | \$85.32 | \$84.34 | 1 | \$0.00 | No further reimbursement is recommended |
| E0191 | \$30.00 | \$0.00 | \$9.99 | 1 | \$9.99 | Allow reimbursement |
| L3999 | \$40.00 | \$0.00 | \$25.00 | 1 | \$24.22 | Allow reimbursement |

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