

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 17, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000967	Date of Injury:	11/19/2013
Claim Number:	[REDACTED]	Application Received:	06/15/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/05/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99213		

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 \$37.69 in additional reimbursement for a total of \$232.69. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$232.69 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, 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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: 1997 E/M Guidelines

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 99213
- Claims Administrator reimbursed \$47.30 for code indicating on the Explanation of Review “Network allowance” and “The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance”
- CPT 99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; an expanded problem focused examination; Medical decision making of low complexity.
- Provider’s submitted a narrative report along with a standard PR-2 form. Narrative report documents a chief complaint, brief HIP and one ROS which qualifies as a 99213. Documentation does support an Expanded Problem Focused History.
- Exam documented on report states 4 Objective findings. In order to qualify for as a 99213 as least six findings are from one or more organ systems is needed. A Problem Focused Exam is supported by documentation submitted and does not qualify as 99213.
- Medical Decision Making documented “We gave her a prescription for a Medrol Dosepak. I explained to her that the only other option we have is surgery and I explained that surgery does not work well for this condition. The patient does not want any surgery”, “The patient will continue with her stretching and strengthening exercises” and “the patient will continue with her usual and customary work duties at this time.”

- Documentation submitted supports a Low Complexity Medical Decision Making of 99213.
- Based on information reviewed, reimbursement of 99213 is warranted as Provider has supported 2 of the 3 components of a 99213.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99213

Date of Service: 1/5/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99213	\$120.00	\$47.30	\$72.70	1	N/A	\$84.99	DISPUTED SERVICE: Allow reimbursement \$37.69

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