

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 14, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000774	Date of Injury:	09/09/2012
Claim Number:	[REDACTED]	Application Received:	05/09/2016
Assignment Date:	05/26/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/14/2016 – 01/14/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99214 and WC002		

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 \$144.84 in additional reimbursement for a total of \$339.84. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$339.84** 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,

MAXIMUS

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
- OMFS

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 seeking remuneration for 99214 Established Patient Evaluation and Management with WC002 Primary Treating Physician Report submitted for date of service 01/14/2016.**
 - EOR's indicate services denied in full as services require prior authorization.
 - Opportunity to Dispute communicated with the Claims Administrator on 05/10/2016: response not yet received.
 - Communication dated 07/24/2016 signed by (Legal Party) indicates Provider is the Designated Primary Treating Physician.
 - Primary Treating Physicians for follow up services on accepted injuries do not require prior authorizations.
 - California Specific Code, WC002 Primary Treating Physician Report code is reimbursable to Primary Treating Physicians when an Injured Worker has been seen for follow-up services on accepted injuries.
 - PR-2 Documentation reflects Injured Worker seen for "follow-up" for "right ankle, right foot and right toes pain," with Ultram (Tramadol) prescription pain management. **WC002 reimbursement is indicated.**
 - 1995/1997 Evaluation and Management Levels/Elements (History / Exam / Medical Decision Making), Established Patient:
 - 99212: Problem Focused / Problem Focused / Straight Forward
 - 99213: Expanded Problem Focused / Expanded Problem Focused / Low Complexity
 - 99214: Detailed History / Detailed Exam / Moderate Complexity
 - 99215 Comprehensive: extended HPI, ROS that is directly related to the problems identified in the HPI plus all additional body systems, and a complete PMFSH.
- 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 (face-to-face) should be documented and the record should describe the counseling and/or activities to coordinate care.
- Abstracted information for date of service 01/207/2016 when compared to 1995/1997 Evaluation and Management Established Patient guidelines revealed the following service:

- **History:**

1. HPI: Brief
2. ROS: Complete
3. Other History: Pertinent
 - PFSH "reviewed, no changes," Unable to Verify as previous medical records not sent.
4. Brief / Complete / Complete = **Detailed**

- **Exam:**

1. **Expanded Problem Focused** - Examination
Extended of affected area / organ system + related / symptomatic areas.

- **Medical Decision Making:**

1. Presenting Problems/Diagnosis = Multiple
2. Complexity of data: Limited
3. Risk: High
 - Pharmacological Pain Management, Tramadol.
4. Multiple / Limited/ High= **Moderate Complexity**

- Established Patient E&M criteria must meet or exceed:

1. **Detailed / Expanded Problem Focused / Moderate Complexity = 99214**

Time Factor for date of service:

- o Not Documented
- Contractual Agreement not submitted for IBR.
Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99214 and WC002.

The table on page 5 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214 & WC002

Date of Service: 01/14/2016							
Provider							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99214	\$181.43	\$0.00	\$181.43	N/A	1	\$132.93	OMFS Refer to Analysis
WC002	\$15.78	\$0.00	\$15.78	N/A	1	\$11.91	OMFS Refer to Analysis

Copy to:

[REDACTED]