MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 24, 2021

REDACTED
REDACTED
REDACTED
REDACTED

IBR Case Number	CB21-0000570
Claim Number	REDACTED
Assignment Date	04/15/2021
Claims Administrator	REDACTED
Date(s) of service	01/04/2021 - 01/04/2021
Provider Name	REDACTED
Employee Name	REDACTED
Disputed Codes	99214 and WC002
Date of Injury	01/08/2020
Application Received	03/25/2021

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 $180.00 for the review cost and $143.64 in additional reimbursement for a total of $323.64. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$323.64** 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 Federal Services

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
- Contractual Agreement

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 seeking remuneration for 99214 and WC002 submitted for date of service 01/04/2021.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 03/30/2021. Response not yet received.
- CMS 1500, place of service 11
    - 99214-95
    - WC002
- EORs reflect zero reimbursement with the rationale: claim/service lacks information or has submission/billing errors which is needed for adjudication.
- Code Description
    - 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
    - WC002: Primary Treating Physician's Progress Report (Form PR-2), issued in accordance with section 9785(f), using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785.
- Submitted Visit Note dated 01/04/2021 supports the following components:
    - Comprehensive History
        - CC
        - Extended HPI: Location, Quality, Severity, Context, Modifying Factors, Associated Signs and Symptoms
        - Complete ROS
        - Complete PFSH
    - Detailed Exam (General Multi System)
        - Constitutional: One bullet
        - Respiratory: One bullet
        - Cardiovascular: Two bullets
        - Gastrointestinal: One bullet
        - Musculoskeletal: Two bullets
        - Skin: One bullet
        - Neurological: Three bullets
        - Psychiatric: Two bullets
    - Low Complexity Medical Decision Making
        - Number of Diagnoses or Treatment Options:
            1. 1 established diagnoses failing to change as expected, worsening, inadequately controlled
        - Reviewed:
            1. CURES report
        - Risk:
            1. Management Options: Prescription Drug Management

    - Abstracted Elements: Comprehensive History/Detailed Exam/ Medical Decision Making of Low Complexity = 99214.
- Submitted documentation supports the two out of three key components needed for 99214. **99214 Overturned.**
- § 9785. Reporting Duties of the Primary Treating Physician.
    - (1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter.
- Submitted letter from the Claims Administrator dated 02/11/2020, identifies the rendering provider as the Primary Treating Physician. Submitted documentation appears to meet the definition of a Primary Treating Physician's Report. **WC002 Overturned.**
- Submitted contractual agreement indicates reimbursement to be the lesser of 83% of the State's applicable fee schedule or 83% Provider's billed charge. 83% OMFS meets the lesser of:
    - 83% Billed Charges: $235.17 * .83 = $195.19
    - 83% OMFS: $173.06 * .83 = $143.64
- OMFS 2020 Geographic Practice Cost Index by locality corresponding to the county where service was provided:
    - Provider Zip: REDACTED
    - Locality: REDACTED, CA
    - 99214 Work RVU + GPCI: 1.5735; Non-Facility PE RVU + GPCI: 1.7951; MP RVU + GPCI: 0.05456
    - WC002: $12.89
- Zero reimbursement received. Reimbursement is due up to the contracted rate of 83% OMFS.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99214 and WC002.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214 and WC002
Date of Service: 01/04/2021
Physician

Service Code	99214
Provider Billed	$160.17
Plan Allowed	$0.00
Dispute Amount	$160.17
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$132.94
Notes	**Overturn** 3.42316 (RVU & GPCI Total) * 46.7900 (CF) = $160.17 * .83 (PPO) = **$132.94** **Due Provider** Refer to Analysis

Service Code	WC002
Provider Billed	$75.00
Plan Allowed	$0.00
Dispute Amount	$75.00
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$10.70
Notes	**Overturn** $12.89 (OMFS) * .83 (PPO) = **$10.70** **Due Provider** Refer to Analysis

Copy to:

REDACTED
REDACTED
REDACTED

REDACTED
REDACTED
REDACTED