Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/24/2013, by the Administrative Director of the California Division of Workers’ Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the Claims Administrator’s determination is upheld. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:
The following evidence was used to support the decision:
- 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
- Other: Official Medical Fee Schedule Physical Medicine Guidelines and Ground rules
Supporting Analysis:
The dispute regards the denial of Evaluation and Management code (99213 Modifier 25) on date of service 03/07/2013. The Claims Administrator denied the billed procedure code 99213 with explanation “Follow up E&M visits may only be reimbursed with acupuncture when there is a change in condition, failure to respond to treatment, discharge or P&S, evaluation service over and above normally provided, or evaluation of patient response to treatment.”

The Independent Bill Review (IBR) case was referred to the Department of Workers’ Compensation (DWC) for an eligibility review. The DWC deemed the case eligible for the IBR process.

The Provider billed the following services for 03/07/2013:

CPT 99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
An expanded problem focused – history; an expanded problem focused – examination; Medical decision making of low complexity.

CPT 97800 – Acupuncture by manual stimulation
CPT 97026 – Physical medicine treatment to one area; infrared
CPT 97014 – Physical medicine treatment to one area; electrical stimulation (unattended)

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service:
The Physician may need to indicate that on the day a procedure or service identified by a CPT code was performed the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure or other service that was performed. This circumstance is reported by adding the ‘-25’ to the appropriate level of E/M service.

The Claims Administrator reimbursed the Provider for the billed procedure codes 97800, 97026 and 97014 and denied the billed procedure code 99213 Modifier 25.

Per the Official Medical Fee Schedule, reimbursement for follow up evaluation and management services for the routine reassessment of an established patient is included in the value of the treatment codes in the Physical Medicine Section of the schedule. Follow up Evaluation and Management services for the re-examination of an established patient may be reimbursed in addition to physical medicine, manipulation, starred procedures and acupuncture only when any of the following applies:

- There is a definite measurable change in the patient’s condition requiring a significant change in the treatment plan.
- The patient fails to respond to treatment requiring a change in the treatment plan.
- The patient’s condition becomes permanent and stationary, or the patient is ready for discharge.
- It is medically necessary to provide evaluation service over and above those normally provided during the therapeutic services and included in the reimbursement for physical medicine treatment (Documentation may be required).
- It is necessary to provide evaluation services to meet the reporting requirements set forth in Title 8, California Code of Regulations Section 9785(f).
The Provider submitted a report titled “Acupuncture Progress Report.” The PR-2 documented an Evaluation and Management with patient on date of service 03/07/2013. The medical record documented the worker’s subjective complaints (anxiety, sleep disturbed); measurable outcomes (reduced anxiety/depression); completed anxiety/stress scale; work status and need for continued treatment. The Medical record documented the following in regards to the need for continued care and treatment: continued sleep problem; patient made reasonable progress toward pre-clinical status or functional outcomes under the treatment plan; ADLs additional significant improvement can be reasonably expected by continued treatment; worker has not reached maximum therapeutic benefit; compliance and cooperation with treatment indicated; and a request acupuncture treatment two times a week for six weeks. The worker was referred back to the Primary Treating Physician for follow-up. The medical record did not illustrate a significant or separately identifiable Evaluation and Management Service performed on 3/7/2013. Based on a review of the medical record, the Evaluation and Management services did not meet the requirements of a follow-up or re-examination of an established patient warranting reimbursement in addition to acupuncture treatment.

There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99213 Modifier 25.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Modifier</th>
<th>Validated Units</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>25</td>
<td>1</td>
<td>$56.93</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>OMFS</td>
</tr>
</tbody>
</table>

**Chief Coding Specialist Decision Rationale:**
This decision was based on Official Medical Fee Schedule, medical record and comparison with explanation of review. This was determined correctly by the Claims Administrator and the payment of $0.00 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[Signature], RHIT

Copy to:
[Redacted]

IBR Final Determination Upheld
Form Effective Date 7.23.13