Dear [Name]:

**Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/7/2014, 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: OMFS Surgery, E&M Guidelines and Ground Rules
Supporting Analysis:

The dispute regards the denial of an Evaluation and Management service performed on 4/12/2013. The Claims Administrator denied the billed CPT code 99213 with the following explanation codes:

- G7 No separate payment was made because the value of the service is included within the value of another service performed on the same day (99213).
- S3 The visit or service billed, occurred within the global surgical period and is not separately reimbursable
- 48 The provider billed for a visit on the same day of surgery or within the follow-up of a previously performed surgery.
- 1056 In regard to the reduction of the office visit billed following a surgery, please see surgery ground rule 2 of the fee schedule. It states: Listed surgical procedures include the operation, local infiltration, metacarpal/digital block, or topical anesthesia when used, and the normal, uncomplicated follow-up care. “No complication and/or exacerbations were documented by the provider's office, and the office visit (s) in question falls within the number of follow-up days listed for the surgical procedure performed. We are unable to recommend any additional allowance.

Upon review of the Progress Report (PR-2), for date of service 4/12/13, exam performed by Physician Assistant and Co-signed by treating physician, and the CMS1500 HCFA form, for the above stated date of service, findings indicate that the service performed was for anything other than postoperative follow-up and adjustment. In addition, the claim lacks the required modifier (25) to identify the level of service to be a “Significant, Separately Identifiable Evaluation and Management Service.”

Subjective Complaints were documented as: “...presents f/u for w/c. Recently had stimulator implant and adjusted to provide greater than 70% relief. Has tapered off current meds and doing well. Good function.”

Disposition: “.....presents f/u for W/C. Recently had stimulator implant and adjusted to provide greater than 70% relief. Has tapered off current meds and doing well. Good function. 1. Refill meds in triplicate 2. f/u prn.”

Operative Reports supplied as part of the documentation indicated the following procedures/operations were performed prior to the 4/12/2013 office visit:

- Date of service 4/2/2013 Dual octrode lead lumbar spinal cord stimulator implant including battery implant, programming of the stimulator, and fluoroscopy
- Date of service 4/10/2013 Wound check and dressing change

Procedure codes assigned to the above referenced operations would have been assigned: 62360, 62361 or 62362.

OMFS list global time frames as 090 for all codes listed above.
No additional reimbursement warranted to the provider as operative service on 4/2/2013 has global
time frame of 90 days.  E/M service performed within global time frame with no separate and distinct
service.

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 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>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 supplied medical record and comparison with OMFS Physician Services.
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,

[Name], RHIT
Chief Coding Reviewer

Copy to:

[Redacted]
[Redacted]

Copy to:

[Redacted]