

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

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**Independent Bill Review Final Determination Reversed**

3/7/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 1/3/2013 – 1/3/2013  
MAXIMUS IBR Case: CB13-0000331

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/28/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$101.26, for a total of \$436.26.**

**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
- Official Medical Fee Schedule or negotiated contract: OMFS
- Other: OMFS Information and Instructions, Evaluation and Management guidelines

**Supporting Analysis:**

The dispute regards the denial of an Evaluation and Management service (99215), report charge (99081) and preventative counseling (99401). The Claims Administrator denied the billed procedure codes 99215 and 99081 with the explanation "We cannot review this service without necessary documentation. Please submit with indicated documentation as soon as possible." The Claims Administrator denied the billed procedure code 99401 with the explanation "The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing."

CPT 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Comprehensive history; comprehensive examination; and medical decision making of high complexity. Usually the presenting problem(s) are of moderate to high severity.

CPT 99081 – Required reports

CPT 99401 - Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.

Modifier 59 – Distinct procedural service

The Independent Bill Review (IBR) case was forwarded to the Department of Workers' Compensation (DWC) for an eligibility review. The case was deemed eligible for IBR by the DWC.

MAXIMUS requested a copy of the PPO contract. The Provider responded to our request with a written statement indicating "No Contract – No Rate Reduction." The Provider's documentation submitted with the Independent Bill Review case included a written appeal with the statement "this bill was properly documented and was never contested." The final explanation of review submitted with the Independent Bill Review case indicated a denial of all billed charges (99215, 99081 and 99401) with the explanation "This appears to be a duplicate charge for a bill previously reviewed, or this appears to be a balance forward bill containing a duplicate charge and billing for a new service." Based on a review of the initial and final explanation of review (EOR), it does not appear the services were denied due to unauthorized services or rendered by an unauthorized or non-contracted provider.

The documentation included a Primary Treating Physician's Progress Report (PR-2). The PR-2 documented an evaluation and management service performed on date of service 1/3/2013. The patient was seen for follow up visit and chief complaint was documented as "FBSS (failed back surgery syndrome), bilateral distal UE (upper extremity) pain." The medical record documented a detailed history which included; chief complaint, extended history of present illness; extended problem pertinent system review (ROS) and pertinent past, family, and/or social history. The medical record demonstrated a detailed musculoskeletal examination of the following areas: cervical spine; lumbar/sacral spine; bilateral upper extremities; and bilateral lower extremities. The Provider documented the assessment and plan: new problem (spondylolisthesis); lumbar series ordered; urine toxicology screen ordered; home exercise program, moist heat and stretches. The Medical decision making was of low to moderate complexity due to the limited number of diagnoses and management options; limited amount of data reviewed; and moderate risk of complications and/or morbidity and mortality. Based on the documentation submitted and the OMFS guidelines, the evaluation and management services did not meet the requirements and/or definition of procedure code 99215. The medical record illustrated two of the three requirement components (detailed history and examination) of the Evaluation and Management code 99214. The description of CPT 99214 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least

two of these three key components: Detailed history; detailed examination; and medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Reimbursement is warranted based on the Evaluation and Management service (99214).

The second disputed code is the report code 99081. The Provider submitted a report titled "Primary Treating Physician's Progress Report (PR-2)." The report documented a treatment authorization request: Lumbar Flex/extension series and a change in location of inpatient rehabilitation center. The report documented the reason for submitting the report as "Periodic Report and Treatment Authorization Request." Based on the documentation, reimbursement is warranted for a Primary Treating Physician's Progress Report (99081).

The third disputed code is the preventative medicine counseling code 99401. The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure". The inclusion of this statement indicates that the procedure can be performed separately but should not be reported when a related service is performed. The services described in the procedure code 99401 are included in the services provided in the Evaluation and Management service code billed on date of service 1/3/2013. Based on the documentation, reimbursement is not warranted for the billed code 99401.

The reimbursement of \$101.26 is warranted per the Official Medical Fee Schedule codes 99214 and 99081. There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99401.

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

| Validated Code | Validated Modifier | Validated Units | Dispute Amount | Total Fee Schedule Allowance | Provider Paid Amount | Allowed Recommended Reimbursement | Fee Schedule Utilized |
|----------------|--------------------|-----------------|----------------|------------------------------|----------------------|-----------------------------------|-----------------------|
| 99214          | 25                 | 1               | \$129.41       | \$89.57                      | \$0.00               | \$89.57                           | OMFS                  |
| 99081          |                    | 1               | \$11.69        | \$11.69                      | \$0.00               | \$11.69                           | OMFS                  |
| 99401          | 59                 | 1               | \$23.80        | \$0.00                       | \$0.00               | \$0.00                            | OMFS                  |

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 99214 and 99081 (\$101.26) for a total of \$436.26.

***The Claims Administrator is required to reimburse the provider \$436.26 within 45 days of date on this notice per section 4603.2 (2a). 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,

Tricia Brantley, RHIT

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]