MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Reversed

4/11/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 3/15/2013 – 3/15/2013
MAXIMUS IBR Case: CB13-0000459

Dear [redacted]

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/7/2013, 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 $44.82, for a total of $379.82.**

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 Modifier 25) and a report service (99081) performed on date of service 3/15/2013. The Claims Administrator denied the billed procedure codes 99215 and 99081 with the explanation "Report necessary for reimbursement. Please resubmit with appropriate report."

The Provider billed the following services for date of service 3/15/2013:

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 25 - Significant, separately identifiable Evaluation and Management service by the same physician on same day of a procedure or other service

The Provider submitted a Primary Treating Physician's Report (PR-2). The Provider billed for preventative medicine counseling using the billed code 99401, and was reimbursed by the Claims Administrator for the billed procedure code 99401. The Evaluation and Management services and documentation of preventative counseling services were documented on the same report.

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 3/15/2013. The chief complaints were documented as "chronic, severe, intractable low back and left lower extremity pain with numbness." The medical record documented an expanded problem focused history which included; chief complaint, brief history of present illness; and problem pertinent system review (ROS). The medical record demonstrated an expanded problem focused musculoskeletal examination of the affected body areas: cervical, thoracic and lumbar spine. The Provider recommended: renewal of medications; home exercise program; and a Medial Branch Block (MBB) bilateral L4-5 and L5-S1. 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 (low complexity medical decision making, expanded problem focused history and examination) of the Evaluation and Management code 99213. The description of CPT 99213 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: expanded problem focused history; expanded problem focused examination; and medical decision making of low complexity. Usually the presenting problem(s) are of low severity. Reimbursement is warranted based on the Evaluation and Management service (99213).

The Provider was reimbursed $20.23 for the billed procedure code 99401. The procedure code 99401 is not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. To report counseling individual patients with symptoms or established illness, the appropriate office, consultation or other evaluation and management code should be used. The Provider reported both the evaluation and management code 99215 and 99401.

Based on a review of the documents, reimbursement is warranted for an evaluation and management code 99213, reimbursement was not warranted for the preventative medicine counseling code 99401; therefore, the recommended reimbursement for the procedure code 99213 reflects the previous payment of $20.23 for the billed procedure code 99401.

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 the reason for submitting the report as "Periodic Report, change in treatment plan, and Schedule II medication refill." The report documented a change in treatment plan, treatment authorization, work status and prognosis. Based on the documentation, reimbursement is warranted for the billed procedure code 99081.

The additional reimbursement of $44.82 is warranted per the Official Medical Fee Schedule codes 99213 and 99081.

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
99213	25	1	$129.41	$56.93	$23.80	$33.13	OMFS
99081		1	$11.69	$11.69	$0.00	$11.69	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 codes 99213 and 99081 ($44.82) for a total of $379.82.

The Claims Administrator *is required to reimburse the provider $379.82 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,

[redacted], RHIT

Copy to:
[redacted]

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