



### Supporting Analysis:

The dispute regards the denial of reimbursement for an evaluation and management service performed on 5/21/2013. The Provider billed CPT codes: 99214 Modifier 25, 99081, 90862 Modifier 59 and was reimbursed \$62.13. The Claims Administrator denied reimbursement on CPT 99214 with the explanation "number of services exceeds utilization agreement. Payment based on individual pre-negotiated agreement for this specific service." The Claims Administrator reimbursed the Provider \$62.13 for billed CPT codes 90862 and 99081.

- **CPT 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. Usually, the presenting problem(s) are of moderate to high severity.
- **CPT 90862:** Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy.
- **Modifier 25:** Current Procedural Terminology (CPT) 1997 guidelines state the following: "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 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 modifier -25 to the appropriate level of E/M service."
- **Modifier 59:** Current Procedural Terminology (CPT) 1997 guidelines state the following: Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury.

The Provider submitted a Primary Treating Physician's Progress Report (PR-2) for date of service 5/21/13. The patient was seen for follow up visit and chief complaint was documented as "back pain." The Interval Changes were documented as "patient has been experiencing severe spasms since Saturday, finally subsiding for the most part yesterday. Otherwise there have been no interval changes since last visit." The medical record documented a detailed history which included; chief complaint, extended history of present illness; problem pertinent system review (ROS) and pertinent past, family, and/or social history. The medical record demonstrated a musculoskeletal examination of the following areas: cervical, thoracic and lumbar/sacral spine. The Provider prescribed new medication Lidoderm 5%; recommended continued home exercise program, moist heat and stretches; requested authorization for bilateral L3/4 and dorsal ramus 5 Medical Branch Block under fluoroscopic guidance; authorization for 6 PT visits for soft tissue mobilization of lumbosacral spine; and follow-up visit in four weeks. . The medical record illustrated at least two of the three requirement components of the Evaluation and Management code 99214.

The CPT code 90862 refers to the in-depth management of psychopharmacologic agents that are potent medications with frequent serious side effects, and represents a very skilled aspect of patient care. The medical record did not document an in-depth management of psychopharmacologic

agents. The medication management service documented in the medical record was a new prescribed medication documented in the Medication Summary: Lidoderm 5% patch apply 2 to lumbar spine; and the Medication Management section: “patient counseled as to the benefits and potential side effects.” The Claims Administrator reimbursed the Provider for the billed CPT code 90862. The medical record documented medication management services typically included in or part of the Evaluation and Management services billed with CPT 99214.

The CPT codes 99214 and 90862 would not be normally billed together. The medical record did not illustrate the service billed as 90862 Modifier 59 was distinct or independent from other service performed on the same day (99214 Modifier 25); therefore reimbursement is recommended for the E/M code 99214. The amount paid by the Claims Administrator for the billed CPT code 90862 was considered as partial reimbursement for the billed CPT 99214.

The additional reimbursement of \$39.14 is warranted per the Official Medical Fee Schedule code 99214.

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	\$89.57	\$89.57	\$50.43*	\$39.14	OMFS

\*Reimbursement amount for the billed CPT code 90862

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 Modifier 25 (\$39.14) for a total of \$374.14.

***The Claims Administrator is required to reimburse the provider \$374.14 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,

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