

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

5/21/2014

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IBR Case Number:	CB13-0000851	Date of Injury:	4/13/2004
Claim Number:	██████████	Application Received:	12/11/2013
Claims Administrator:	██████████		
Date(s) of service:	6/10/2013 – 6/10/2013		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	99215		

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/31/2013, 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: OMFS Information and Instructions, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the denial of an Evaluation and Management service (99215) performed on 6/10/2013. The Claims Administrator denied the billed procedure code 99215 with the explanation "The visit falls within the surgical follow-up days of another procedure. According to the OMFS, the surgical procedure performed on 5/23/2013 includes the operation per se, local infiltration, metacarpal/digital block, or topical anesthesia when used, and the normal, uncomplicated follow-up care. This concept is referred to as a "package" for surgical procedures. Since the office visit falls within the 90 day follow-up care of the surgical procedure it is included and does not warrant separate reimbursement."

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

The Provider submitted a medical record documenting an evaluation and management service performed on date of service 6/10/2013. The chief complaint was documented as "H/O neck, arm, back and leg pain. Completed therapeutic right C3, C4, C5, and C6 median branch radiofrequency neurotomy (CPT 64620-64623) on 5/23/2013. Worker is reporting 90+% relief of the right upper back, neck, and shoulder burning pain. Mid-thoracic pain is markedly elevated and interfering nightly with sleep." The medical record documented a history and physical exam of the spine and upper and lower extremities. The Provider requested authorization for the following: right thoracic T7, T8, T9 and T10 median branch nerve radiofrequency neurotomy. The Assessment and Plan section of the report documented: continued current medications; home exercise, home heat and ice therapy; and follow-up appointment in one month. The Evaluation and Management services documented did not indicate an assessment or treatment of a condition at another anatomic location other than the spine. The Claims Administrator denied the Evaluation and Management services as included in the value of or surgical package of the median branch radiofrequency neurotomy performed on 5/23/2013. The surgical procedure has a 90 day follow-up global period. The Operative Report indicated the procedure performed as "Therapeutic right C3, C4, C5 and C6 median branch nerve radiofrequency neurotomy" was performed on 5/23/2013 by the same Provider rendering the Evaluation and Management services on 6/10/2013. Evaluation and Management codes should not be billed for services related to the surgical procedure during the global period. Evaluation and Management services for conditions at other anatomic locations than the global surgical procedure may be reported during the global period if the medical necessity of performing an Evaluation and Management service is supported and the documentation supports the level of service.

Based on the documentation, it does not appear the Evaluation and Management services documented were considered significant and separately identifiable services unrelated to a post-operative visit; therefore, no additional reimbursement is warranted for the billed procedure code 99215.

There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99215.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99215	1	\$129.41	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Information and Instructions, Evaluation and Management guidelines and comparison with explanation of review (EOR). 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,

██████████, RHIT

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