

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

3/14/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/7/2013 – 3/7/2013
MAXIMUS IBR Case: CB13-0000103

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/24/2013, 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: Official Medical Fee Schedule Physical Medicine Guidelines and Ground rules

Supporting Analysis:

The dispute regards the denial of Evaluation and Management code (99213 Modifier 25) on date of service 03/07/2013. The Claims Administrator denied the billed procedure code 99213 with explanation "Follow up E&M visits may only be reimbursed with acupuncture when there is a change in condition, failure to respond to treatment, discharge or P&S, evaluation service over and above normally provided, or evaluation of patient response to treatment."

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

The Provider billed the following services for 03/07/2013:

CPT 99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

An expanded problem focused – history; an expanded problem focused – examination; Medical decision making of low complexity.

CPT 97800 – Acupuncture by manual stimulation

CPT 97026 – Physical medicine treatment to one area; infrared

CPT 97014 – Physical medicine treatment to one area; electrical stimulation (unattended)

Modifier 25 – 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 a 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 '-25' to the appropriate level of E/M service.

The Claims Administrator reimbursed the Provider for the billed procedure codes 97800, 97026 and 97014 and denied the billed procedure code 99213 Modifier 25.

Per the Official Medical Fee Schedule, reimbursement for follow up evaluation and management services for the routine reassessment of an established patient is included in the value of the treatment codes in the Physical Medicine Section of the schedule. Follow up Evaluation and Management services for the re-examination of an established patient may be reimbursed in addition to physical medicine, manipulation, starred procedures and acupuncture only when any of the following applies:

- There is a definite measurable change in the patient's condition requiring a significant change in the treatment plan.
- The patient fails to respond to treatment requiring a change in the treatment plan.
- The patient's condition becomes permanent and stationary, or the patient is ready for discharge.
- It is medically necessary to provide evaluation service over and above those normally provided during the therapeutic services and included in the reimbursement for physical medicine treatment (Documentation may be required).
- It is necessary to provide evaluation services to meet the reporting requirements set forth in Title 8, California Code of Regulations Section 9785(f).

Copy to:

[REDACTED]