

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Upheld

4/11/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/17/2013 – 1/17/2013
MAXIMUS IBR Case: CB13-0000245

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/27/2014, 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, Surgery Guidelines

Supporting Analysis:

The dispute regards the denial of an Evaluation and Management service (99215) and prolonged services (99358) performed on 1/17/2013. The Claims Administrator denied the billed procedure code 99215 with the explanation "The visit or service billed, occurred within the global surgical period and is not separately reimbursable." The Claims Administrator denied the billed procedure code 99358 with the explanation "Insufficient documentation, there is nothing in the medical record to substantiate billed charges. The narrative does not include records reviewed."

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 99358 - Prolonged Evaluation and Management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records, job analysis, evaluation of ergonomic status, work limitations, work capacity, or communication with other professionals and/or the patient/family); each fifteen minutes.

Per the Official Medical Fee Schedule Surgery General Information and Ground Rules, under most circumstances, including ordinary referrals, the immediate preoperative visit in the hospital or elsewhere necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed value for the surgical procedure.

The Provider submitted a medical record documenting an evaluation and management service performed on date of service 1/17/2013. The patient was seen for follow up visit. The medical record documented a history and physical. The subjective complaints documented the worker was seen for a "review of progress" and documented "significant improvement in pain since radiofrequency facet injection." Per the operative report submitted, the procedure performed was 64622 and 64623 on date of service 11/6/2012. The description of CPT 64622 is "Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, single level." Based on the documentation submitted, it appears the visit was a post-surgical follow-up of the procedures performed on 11/6/2012. The procedure code 64622 has a 90 day follow-up global period. The Provider performing the follow-up visit was documented as the attending surgeon on the operative report for date of service 1/17/2013. 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.

The second disputed code is CPT 99358. The medical record for date of service 1/17/2013 indicated 15 minutes of time spent on reviewing "UR 12/28/12 scan." Per the medical record documentation, the time spent reviewing the UR scan was not documented as additional time spent before or after the direct patient care; therefore, it appears the services were included in the evaluation and management post-operative services. Based on the documentation submitted, the billed prolonged services (99358) do not warrant reimbursement.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99215 and 99358.

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
99358	1	\$36.34	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Information and Instructions, Sugery Guidelines and comparison with explanation of review. 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

Copy to:

██
 ██
 ██
 ██
 ██

Copy to:

██
 ██
 ██