

**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**

3/28/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 2/14/2013 – 2/14/2013  
MAXIMUS IBR Case: CB13-0000246

Dear [REDACTED]

**Determination**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/15/2013, 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), report charge (99081) and preventative counseling (99401). The Claims Administrator denied the billed procedure code 99215 with the explanation "Separate E&M services, same physician, visit falls within surgery follow-up period, included in global surgical period." The Claims Administrator denied the billed procedure code 99081 with the explanation "Report does not meet payable guidelines. Last report paid PR2 1/17/2013; under 30 days; Does not meet any of the guidelines on pg. 5 on the OMFS." The Claims Administrator denied the billed procedure code 99401 with the explanation "Denied as 'separate procedure' see ground rules."

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

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

Modifier 59 – Distinct procedural service

Modifier 93 – Interpreter required at the time of examination: Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.1. Prolonged service codes may not be used in combination with this modifier unless it is documented that the reason for the code is additional time required as a result of factors beyond the need for an interpreter.

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 2/14/2013. The patient was seen for follow up visit and chief complaint was documented as "leg pain." The medical record documented a history and physical. The medical record for date of service 2/14/2013 documented a scheduled SCS (Spinal Cord Stimulator) implantation on 2/18/2013. The surgical procedure risks, benefits and alternatives were discussed. Educational information, pre-operative instructions were given and the patient agreed to proceed with the scheduled procedure. Based on the medical record documentation, it appears the documented Evaluation and Management services performed were pre-operative services included in the surgical package. The surgical package includes The Evaluation and Management encounter subsequent to the decision for surgery and immediately prior to the date of procedure (includes history and physical). Due to the surgery had already been scheduled, the visit on 2/14/2013 did not appear to be the "decision for surgery" visit; therefore, the evaluation and management services performed on 2/14/2013 were considered pre-operative services and included in the global surgical package and not separately reimbursable.

The second disputed code is the report code 99081. The Provider submitted a report titled "Secondary 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 did not document a change in treatment plan. The Assessment and Plan indicated the following: renewal of medications (Percocet, and Senna); continue with home exercise program, moist heat and stretches; scheduled SCS implantation 2/18/2013; follow-up visit 4 weeks; and urine

toxicology screening. Per the Claims Administrator's denial of procedure code 99081, the last PR-2 was reimbursed for date of service 1/17/2013. Based on the documentation, it does not appear there was a change in the patient's treatment or condition. The denial of the billed procedure code 99081 by the Claims Administrator was correct.

The third disputed code is the preventative medicine counseling code 99401. The procedure code 99401 is not be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. Based on the documentation, reimbursement is not warranted for the billed code 99401.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99215 Modifier 25, 93, 99081 and 99401.

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

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99215	25	93	1	\$142.35	\$0.00	\$0.00	\$0.00	OMFS
99081			1	\$11.69	\$0.00	\$0.00	\$0.00	OMFS
99401			1	\$75.00	\$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

Copy to:

████████████████████  
 ██████████  
 ██████████

Copy to:

██  
 ██████████ ██████████  
 ██████████