

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

3/6/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 2/26/2013 – 2/26/2013
MAXIMUS IBR Case: CB13-0000254

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/17/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$68.62, for a total of \$403.62.**

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
- Official Medical Fee Schedule or negotiated contract: OMFS
- Other: OMFS Information and Instructions, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the denial of an Evaluation and Management service (99215) and a report charge (99081). The Claims Administrator denied the billed procedure codes 99215 and 99081 with the explanation "Payment based on individual pre-negotiated agreement for this specific service."

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

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.

MAXIMUS requested a copy of the PPO contract. The Provider responded to our request with a written statement indicating "No Contract – No Rate Reduction." The Provider's documentation submitted with the Independent Bill Review case included a written appeal with the statement "We do not have a Pre-Negotiated Agreement for zero pay." The Claims Administrator's explanation of review did not indicate a reason for denial other than the explanation "Payment based on individual pre-negotiated agreement for this specific service." Based on a review of the initial and final explanation of review (EOR), it does not appear the services were denied due to services rendered by an unauthorized or non-contracted provider.

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 2/26/2013. The patient was seen for follow up visit and chief complaint was documented as "chronic lower back pain." The medical record documented an expanded problem focused history which included; chief complaint, brief history of present illness; problem pertinent system review (ROS) and pertinent past, family, and/or social history. The medical record demonstrated an expanded problem focused musculoskeletal examination of the following areas: cervical spine; and lumbar/sacral spine. The Provider documented the assessment and plan: decrease medication (Oxycodone); renew medications (Oxycontin, Gabapentin, and Diclofenac); urine toxicology screen; continued home exercise plan, moist heat and stretches; psychological evaluation; and intrathecal test pump trial. The Medical decision making was of low to moderate complexity due to the limited number of diagnoses and management options; limited amount of data reviewed; and moderate risk of complications and/or morbidity and mortality. Based on the documentation submitted and the OMFS guidelines, the evaluation and management services did not meet the requirements and/or definition of procedure code 99215. The medical record illustrated two of the three requirement components (expanded problem focused history and examination) of the Evaluation and Management code 99213. The description of CPT 99213 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Expanded problem focused history; expanded problem focused examination; and medical decision making of low complexity. Usually the presenting problem(s) are of low to moderate severity. Reimbursement is warranted based on the Evaluation and Management service (99213).

The second disputed code is the report code 99081. The Provider submitted a report titled "Primary Treating Physician's Progress Report (PR-2)." The report documented a change in the worker's treatment plan: decrease in prescribed medication (Oxycodone); psychological evaluation: and

intrathecal test pump trial. The report documented the reason for submitting the report as "Periodic Report and change in treatment plan." Based on the documentation, reimbursement is warranted for a Primary Treating Physician's Progress Report (99081).

The reimbursement of \$68.62 is warranted per the Official Medical Fee Schedule codes 99213 and 99081.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99213	1	\$129.41	\$56.93	\$0.00	\$56.93	OMFS
99081	1	\$11.69	\$11.69	\$0.00	\$11.69	OMFS

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 99213 and 99081 (\$68.62) for a total of \$403.62.

The Claims Administrator is required to reimburse the provider \$403.62 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,

██████████, RHIT

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