

MAXIMUS FEDERAL SERVICES, INC.

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

11/8/2013

Independent Bill Review Final Determination Reversed

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/14/2013 – 3/14/2013
MAXIMUS IBR Case: CB13-0000294

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/21/2013, 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 \$56.93, for a total of \$391.93.**

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 Evaluation and Management and Surgery Guidelines

Supporting Analysis:

The dispute regards the denial of reimbursement for Evaluation and Management services (99214 Modifier 25) and preventative medicine counseling (99401). The Claims Administrator denied reimbursement on the Evaluation and Management service 99214 and indicated "Separate E&M service, same physician, visit falls within a surgery follow-up period, included in global surgical period." The Claims Administrator denied the billed procedure code 99401 indicating "Paid at rate and rules of contract indicated, denied as a "separate procedure". See ground rules."

The Provider billed the following services for date of service 3/14/2013:

CPT 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Detailed history; Detailed examination; Medical decision making of moderate complexity. Usually, the presenting problems are of moderate to high severity.

CPT 63690 - Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); without reprogramming of pulse generator.

CPT 99401 - Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.

CPT 99081 - Required reports.

Modifier 25 - Significant, separately identifiable Evaluation and Management service by the same physician on the same day of a procedure or other service.

The Claims Administrator reimbursed the Provider for the billed procedure codes 63690, 99081 and denied 99214 and 99401.

An Evaluation and Management service is reimbursable with CPT 63690 when a significant and separately identifiable Evaluation and Management service is performed and documented in the medical record on the same day of the procedure.

The documentation submitted included a Secondary Treating Physician's Progress Report for date of service 3/14/2013. The Secondary Treating Physician's Progress Report did demonstrate a significant or separately identifiable E/M service was provided in addition to the electronic analysis of implanted pulse generator. The medical record documented an expanded problem focused history which included: chief complaint, history of present illness; and a problem pertinent system review. The workers current complaints were documented as chronic low back, groin and bilateral lower extremity pain. The presenting problems are considered low severity as there is little to no risk of mortality without treatment and risk of morbidity without treatment is low. The medical record demonstrated an expanded problem focused examination of the following areas: lower extremities, thoracic, lumbar and sacral spine. The medical record did not document all of the required elements of a musculoskeletal examination as would be required in a detailed examination. The Provider requested authorization for follow-up visit, urologic consultation and prescription medications Senna, Voltaren, and Percocet. The medical decision making appears to be of low to moderate complexity due to: presenting problems are chronic but stable and management options are of low to moderate risk. The Evaluation and Management services documented in the medical record met the requirements of CPT 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; Medical decision making of low complexity. Usually, the presenting problems are of low to moderate severity." The denial of the Evaluation and Management services by the Claims Administrator was not correct. The reimbursement of the Evaluation and Management services should have been based on CPT 99213.

The second disputed code is 99401. Per a review of the OMFS Evaluation and Management guidelines, preventative medicine and individual counseling codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. The denial of billed procedure code 99401 by the Claims Administrator was correct.

There is no additional reimbursement warranted per Official Medical Fee Schedule code 99401. The additional reimbursement of \$53.93 is warranted per Official Medical Fee Schedule code 99213.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date 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
99213	25		1	\$89.57	\$56.93	\$0.00	\$56.93	OMFS
99401			1	\$23.80	\$0.00	\$0.00	\$0.00	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 Modifier 25 (\$56.93) for a total of \$391.93.

The Claims Administrator is required to reimburse the provider \$391.93 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,

[REDACTED], RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]