

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

6/4/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000934	Date of Injury:	1/30/1977
Claim Number:	[REDACTED]	Application Received:	12/23/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	9/12/2013 – 9/12/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99214		

Dear Marc Wolfsohn, MD:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/16/2014, 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 General Information and Instructions, Evaluation and Management Guidelines

Supporting Analysis:

The dispute regards the denial of Evaluation and Management code (99214) on date of service 09/12/2013. The Claims Administrator denied the billed procedure code 99214 with the explanation “The visit or service billed, occurred within the global surgical period and is not separately reimbursable”.

The Provider billed the following services for date of service 09/12/2013:

CPT 99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patients and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

CPT 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour

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

CPT 99081 – Required Reports

The Claims Administrator reimbursed the Provider for the billed procedure codes 99358, 99401, 99081, and denied the billed procedure code 99214.

The Provider submitted a SOAP report for an office visit (established patient), with the visit type: follow-up. The chief complaint documented was low back pain. The history of present illness (HPI), review of systems (ROS), and past medical and family, history was documented. A physical examination was documented with comments that there are multiple healed scars and there is atrophy of the LLE right by approx 50 percent, no signs of infection, and well healed procedure sites with no signs of infection. The medical record included that the patient was recovering from the Lumbar Rhizotomy. The visit also included the following: diagnostic CURES review; prescriptions; assessment and plan. MAXIMUS issued a request for operative report documents pertaining to the global period referenced on the explanation of review (EOR); the requested documents were not received. Based on the review of the medical record and the Evaluation and Management service, there were no other conditions documented outside of the follow up for the low back pain. The Evaluation and Management services performed on date of service 9/12/2013 appear to be a follow up to the Lumbar Rhizotomy procedure; therefore, reimbursement for the billed evaluation and management code 99214 is not recommended

There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99214.

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 Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99214	24	1	\$89.57	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Evaluation and Management Guidelines, medical record 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,

[Redacted signature]

[Redacted address]

Copy to:
Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612