

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

9/12/2014

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

IBR Case Number:	CB14-0000113	Date of Injury:	06/02/2000
Claim Number:	[REDACTED]	Application Received:	01/27/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/08/2013 – 03/08/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215 -25		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/28/2014, 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: PPO Contract

Supporting Analysis:

The dispute regards the non-reimbursement of services from Provider to Claims Administrator for date of service 03/08/2013. The specific code in question is CPT 99215 -25, in the amount of \$129.41. On 04/03/2013, the Claims administrator initially denied the claim stating:

1. "Included in global surgical package,"
2. "Visit falls within a surgery follow-up period."

A request for a second review by the Provider to the Claims Administrator was requested. The outcome of the second review by the on 12/06/2013 echoed the initial review with an additional statement, "No additional reimbursement allowed."

For the purposes of this Independent Bill Review, the code in question will be discussed and compared with the documentation provided and the guidelines specific to that code.

The American Medical Association Current Procedural Terminology Code Book, 1997 defines the code in question as follows:

- **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:
 - a comprehensive history;
 - a comprehensive examination;
 - medical decision making of high complexity.

To discern whether or not the documentation provided fits the criteria of CPT 99215, the total services for the date of service in question must first be reviewed as service codes are often interconnected and determine the outcome of payment for said services as specified by the guidelines which govern them.

Two additional CPT codes were billed for this date of service and claim; AMA CPT definitions are as follows:

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

Title 8, California Code of Regulations Section 9785(f), defines the last CPT as follows:

- **CPT 99081**
 - Using DWC Form PR-2 or its equivalent (see Appendix D), when (1) the employee's condition undergoes a previously unexpected significant change; (2) there is any significant change in the treatment plan reported in the Doctor's First Report including, but not limited to, an extension of duration or frequency of treatment, a new need for hospitalization or surgery, a new need for referral to or consultation by another physician, a change in methods of treatment or in required physical medicine services, a need for rental or purchase of durable medical equipment or orthotic devices; (3) the employee's condition

permits return to modified or regular work, but the employee has not reached permanent and stationary status; (4) the employee's condition requires him or her to leave work or requires a change in work restrictions or modifications; (5) the employer reasonably requests additional appropriate information. (6) A progress report shall be submitted no later than 45 days from the submission of the last progress report even if no event described in paragraphs (1)-(5), above, has occurred. Progress reports are separately reimbursable even if the change in the patient's condition or treatment warranting a progress report occurs during the surgical global follow-up period.

The initial processed claim stated the services fell within a global period for surgical services previously performed; without the entire medical record, the ability to verifying this fact is inhibited. Since the Claims Administrator provided this statement and has access to the medical billing history for this case, the denial statements provided regarding surgery will be considered factual in absence of the entire medical record and if warranted, factored into the final decision of this review.

Upon review of the documentation, the IBR noted the following:

- The Provider completed a five page PR-2 report for this date of service and was reimbursed by the Claims Administrator for this CPT 99081 for the claim on 04/03/13.
- A sixth page is attached to the referenced PR-2. This section is entitled "Medication Management." During the session, the Provider discussed the "benefits" as well as the "potential side effects" and was prescribed a prescription of "Percocet 10-325 mg, #90" The Provider submitted CPT 99401 for this service on the date in question and was denied reimbursement.

Documentation for the separate service charge, CPT 99215 – 25, could not be ascertained. The "Chief Complaint" states, "Lumbar pain with radicular pain to the right lower extremity," and the "History of Present Illness" states, "Patient comes in and reports the RFA helped control the pain for 80%. He reports it made a big difference. He is doing better." The logical relationship of these two statements indicate that the patient is 80 % better since the radiofrequency ablation treatment and is being seen as a follow up. In this case, the key factor separating a billable versus a non-billable (post-operative/procedure) service is the actual date of the RFA; the relevancy of a global period is an integral aspect of contractual billing guidelines. Attempts to clarify the actual date of the RFA within the PR-2, was not successful. The only information indicating whether or not the service is within or is not within the global period is the information supplied by the Claims Administrator on the EOR. Since the chart documentation supplied did not indicate the date of the RFA, the EOR global period reference must be taken into consideration. Based on the documentation provided for CPT 99215 – 25, remuneration cannot be recommended.

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
99215	25	1	\$129.41	\$0.00	\$0.00	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on the aforementioned guidelines and comparison with the OMFS. 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], RHIT
Chief Coder

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
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