A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/25/2013, 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 $318.99, for a total of $653.99.

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: PPO Contract
- Other: OMFS Information and Instructions, Evaluation and Management guidelines
Supporting Analysis:
The dispute regards the payment amount for office consultation services (99244) and denial of reimbursement for a consultation report (99080) and prolonged services (99358). The Claims Administrator based its reimbursement of the billed CPT code 99244 on CPT code 99204 with the explanation "The above code has been recommended in lieu of 99244 as it appears the provider has assumed care of the patient and is not acting as a consultant. The assigned code best describes services rendered, per ca fee schedule." The Claims Administrator denied the billed CPT 99080 with the explanation "The billing reflects procedure 99080 special reports. Per OMFS no allowance is made for standard treatment reports as this is a requirement of the treating physician, as stated in California code regulations and is included in the E/M service." The Claims Administrator denied the billed CPT code 99358 with the explanation "Per OMFS 99358, prolonged mgmt service is for reviewing extensive outside records, tests, or in communication with other professionals. Per report OMFS guidelines were not met. Preparation of report/review of your own records does not warrant this charge.

CPT 99244 - Office consultation for a new or established patient, which requires these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of moderate complexity.
CPT 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.
CPT 99358 - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records, job analysis, evaluation of ergonomic status, work limitations, work capacity or communication with other professionals and/or the patient/family); each 15 minutes.

The Provider submitted an "Initial Comprehensive Dermatologic Evaluation Report." The report was addressed to the Claims Administrator, and documented the worker was referred to the Provider for a dermatologic evaluation. The report documented the worker's history related to the dermatologic complaints and an examination of integumentary system. The Provider documented in the Worker's History, worker has been following up with a dermatologist for the past 15 years and was treated for actinic keratoses on the arms and face with liquid nitrogen about four times a year. Per the report, the worker will continue to follow-up with her dermatologist in Orange County. The recommendations documented in the medical record consisted of: follow-up with her local dermatologist; skin biopsies of the atypical nevi (left buttocks and lateral waist); actinic keratosis treatment; and periodic dermatologic re-evaluations two to three times a year, sunscreen and sun-protective hat. The Provider made recommendations for future medical care and treatment, but did not indicate care of the worker had been assumed at the time of the evaluation. Based on the documentation, it appears the evaluation met the OMFS requirements and definition of a consultation. Per the OMFS General Information and Instructions, A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The documentation indicates the consultation was requested by an appropriate source (Claims Administrator). Therefore, reimbursement of 99204 by the Claims Administrator was not correct. The description of CPT 99204 is "Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of moderate complexity." Reimbursement is warranted for the billed outpatient consultation code 99244.
The second disputed code is report code (99080). Per the OMFS General Information and Instructions, consultation reports (99080) are separately reimbursable when consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. The Evaluation and Management services submitted by the Provider met the requirements of a consultation, therefore, reimbursement is warranted for the billed CPT code 99080 (6 units).

The third disputed code is the prolonged evaluation and management services (99358). Based on a review of the OMFS General Information and Instructions, Prolonged Evaluation and Management Service (99358) is used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual service in either the inpatient or outpatient setting. The prolonged service code (99358) may also be used when the physician is required to spend 15 or more minutes reviewing records or tests, a job analysis, and evaluation of ergonomic status, work limitations, or work capacity when there is no direct (face-to-face) contact.

The report documented 75 minutes of time spent on "reviewing records, compiling data, reviewing, dictating and editing the report." The report documented a review of the work restrictions and permanent impairment due to skin disorder. The report documented a review of the treating dermatologist records and related documentation for workers' compensation claim. Based on the documentation, reimbursement is warranted for the prolonged service code 99358 (5 units).

The additional reimbursement of $318.99 is warranted per the Official Medical Fee Schedule codes 99244, 99080 and 99358.

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

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Modifier</th>
<th>Validated Units</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>99244</td>
<td></td>
<td>1</td>
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<td>$157.13</td>
<td>$124.20</td>
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</tr>
<tr>
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<td></td>
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<td>$131.61</td>
<td>PPO Contract</td>
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<tr>
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<td></td>
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<td>$154.45</td>
<td>$0.00</td>
<td>$154.45</td>
<td>PPO Contract</td>
</tr>
</tbody>
</table>

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 99244, 99080, 99358 ($318.99) for a total of $653.99.

The Claims Administrator is required to reimburse the provider $653.99 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,

[signature]
RHIT

IBR Final Determination Reversed
Form Effective 7.22.2013