Dear [Name]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/24/2014, 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, American Medical Association Current Procedural Terminology (AMA, CPT)
Supporting Analysis:

The dispute regards the payment amount for an office consultation (99245) and report (99080). The Provider billed CPT 99245 and 99080, was reimbursed $131.51 and is requesting additional reimbursement of $131.51. The Claims Administrator based its reimbursement on CPT 99204 for the billed procedure code 99245 with the explanation "The above code has been recommended in lieu of 99245 as per attached documentation the patient was referred for treatment. Therefore, per the fee schedule the evaluation would not be considered a consultation." The Claims Administrator denied the billed procedure code 99080 indicating "Per OMFS this classifies as an initial report and as such is inclusive with the value of the initial visit. No allowance can be made for this service."

CPT 99245 - Office consultation for a new or established patient, which requires 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. (AMA, CPT)

CPT 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. (AMA, CPT)

OMFS General Information and Instructions states, “The referral for the transfer of the total or specific care of a patient from one physician to another does not constitute a consultation.” A written request or authorization for the consult and/or treatment from the treating physician or Claims Administrator was not received as part of the documentation submitted. Based on the documentation submitted and the OMFS guidelines, the evaluation and management services did not meet the requirements and/or definition of a consultation.

The documentation submitted for review included an “Initial Hand Surgical Consultation” report. Page 1 of the Provider’s report indicated, the worker was referred to the Provider by the Primary Treating Physician for an orthopedic consultation and the Claims Examiner authorized the evaluation. It was noted, the Claims Administrator’s authorization was not submitted as part of the documentation. The medical record documented a problem focused history which included; chief complaint; and history of present illness. The history of present industrial injury was documented as “…bilateral had numbness and tingling. The patient reports that numbness and tingling is predominantly in the median nerve distribution.” The medical record documented physical examination of the following areas: bilateral upper extremities. The Provider’s recommendations: staged bilateral carpal tunnel release; and course of elbow splinting.

The medical documentation supplied did not demonstrate all of the required elements of CPT 99245. Page 3 of the consultation report indicated a recommendation of staged bilateral carpal tunnel release beginning with the right side, and “will await authorization for staged bilateral carpal tunnel releases.” It appears the Provider has assumed treatment of injured worker and is not providing consultation services.

In review of the explanation of review (EOR) and payment, the Claims Administrator based it’s reimbursement of the billed code CPT 99245 on CPT 99204.

CPT 99204: 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. Usually, the presenting problem(s) are of moderate to high severity. (AMA, CPT)
The IBR reviewers were unable to recommend a higher level of Evaluation and Management code other than that of the Claims Administrator's reimbursement of CPT 99204. Thus, no additional reimbursement is recommended.

The second disputed code is CPT 99080. The Provider submitted an "Initial Hand Surgical Consultation" report. The report submitted by the Provider is considered the initial treatment report and plan. Per the OMFS General Information and Instructions, the initial treatment report and plan is not a separately reimbursable report. The denial of CPT 99080 by the Claims Administrator was correct.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99245 (reimbursed as 99204) and 99080.

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

<table>
<thead>
<tr>
<th>Validated Code</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>99204</td>
<td>1</td>
<td>$131.51</td>
<td>$131.51</td>
<td>$131.51</td>
<td>$0.00</td>
<td>PPO Contract</td>
</tr>
<tr>
<td>99080</td>
<td>4</td>
<td>$100.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>PPO Contract</td>
</tr>
</tbody>
</table>

Chief Coding Specialist Decision Rationale:

This decision was based on the supplied medical record, explanation of review and comparison with OMFS Physician Services Fee Schedule. This was determined correctly by the Claims Administrator and the payment of $131.51 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,

[Name], RHIT
Chief Coding Reviewer

Copy to:

[Name]

Copy to:

IBR Final Determination Upheld
Form Effective Date 7.23.13