

Supporting Analysis:

The dispute regards the denial of reimbursement for Evaluation and Management services (99373), report code (99080) and prolonged services (99358). The Claims Administrator denied the billed codes 99373, 99080 and 99358 with the explanation "Documentation does not support the billed charge, no recommendation of payment can be made. Billing for the report and/or record review exceeds reasonableness."

The Independent Bill Review (IBR) was submitted to the Department of Workers' Compensation (DWC) for an eligibility review. The case was deemed eligible by the DWC for the IBR process.

CPT 99373 - Telephone call by a physician to patient for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan.

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 a Primary Treating Physician's Report. The report documented a phone call with the patient on date of service 4/18/2013. Per the report, the worker was scheduled for a follow-up visit and was unable to make the visit and called in to discuss the case over the phone. The phone conversation was documented and described as "lengthy phone call with worker lasting approximately 30 minutes." The report documented a discussion regarding: Results of QME; Work schedule; surgical treatment; pre-operative measures; and other treatment issues. The treatment plan was documented and discussed with worker: Surgery; Utilization review appeal; and pre-operative and post-operative medications, services and treatment. Based on the review of the documentation, the report documented a lengthy phone call with the worker to coordinate services of different health professionals for patient care plan. Reimbursement is warranted for the billed procedure code 99373.

The second disputed code is the report code 99080. The Provider submitted a "Primary Treating Physician Report." The report does not meet the Official Medical Fee Schedule guidelines for a separately reimbursable report. A written request from the Claims Administrator for a report (99080) was not received as part of the documentation. The report was not a result of a change in the worker's condition, treatment or work status. It appears the report was documentation of the phone call that took place in lieu of a face-to-face Evaluation and Management service. Based on the submitted documentation, the report submitted does not warrant reimbursement.

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 thirty minutes of record review: multiple utilization reports; QME exam; and other Records regarding utilization reviews. The Provider billed for two units of procedure code 99358. Reimbursement is warranted for the procedure code 99358.

The reimbursement amount of \$136.13 is warranted per the Official Medical Fee Schedule codes 99373 and 99358. There is no reimbursement and/or allowance warranted per the Official Medical Fee Schedule code 99080.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99358	2	\$76.50	\$71.23	\$0.00	\$71.23	PPO Contract
99373	1	\$69.70	\$64.90	\$0.00	\$64.90	PPO Contract
99080	2	\$64.58	\$0.00	\$0.00	\$0.00	PPO Contract

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 codes 99373 and 99358 (\$136.13) for a total of \$471.13.

The Claims Administrator is required to reimburse the provider \$471.13 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,

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