

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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12/4/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 2/14/2013 – 2/14/2013
MAXIMUS IBR Case: CB13-0000344

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/30/2013, 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 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

Supporting Analysis:

The dispute regards the payment amount for an office consultation (99244) and report (99080). The Provider billed CPT 99244 and 99080, was reimbursed \$93.47 and is requesting additional reimbursement of \$556.14. The Claims Administrator reimbursed \$93.47 for the billed procedure code 99244 indicating "The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description." The Claims Administrator denied the billed procedure code 99080 indicating "This charge was adjusted to comply with the rate and rules of the contract indicated."

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. Usually, the presenting problem(s) are of moderate to high severity.

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

Per a review of the CPT descriptions, the medical record must document and meet all three required components of office consultation code. The medical record did not demonstrate all the components for 99244.

Based on a review of the report submitted by the Provider, the worker was referred to the Provider for a dermatologic consultation. The medical record documented an expanded problem focused history which included; chief complaint, history of present illness; and problem pertinent review of systems (ROS). The diagnoses were documented as dermatitis of hands, right forearm and upper lip. The presenting problems are considered low severity as the risk of morbidity without treatment is low. The medical record demonstrated a problem focused examination. The Provider's recommendations included topical steroids, blood testing, skin fungal culture, skin biopsy, and skin patch testing. The medical record did not demonstrate all of the required elements of CPT 99244.

Per the OMFS General Information and Instructions, 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.

Based on a review of the explanation of review (EOR) and payment, the Claims Administrator based its reimbursement of the billed code CPT 99244 on CPT 99203. The definition of CPT 99203 is "Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: Detailed history; Detailed examination; and Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity." Based on the medical record submitted, MAXIMUS could not recommend an Evaluation and Management code with a reimbursement higher than the amount paid by the Claims Examiner. The Claims Administrator's reimbursement of CPT 99203 was correct.

The second disputed code is CPT 99080. The Provider submitted an "Initial Comprehensive Dermatologic Evaluation Report and Request for Authorization" 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.

