

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280

12/3/2013

Independent Bill Review Final Determination Reversed

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator Name: [REDACTED]
Date of Disputed Services: 1/14/2013 – 1/14/2013
MAXIMUS IBR Case: CB13-0000349

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/29/2013, 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 \$410.75, for a total of \$745.75.**

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 an office consultation (99244 Modifier 93), report (99080) and prolonged services (99358 & 99354). The Claims Administrator based its reimbursement of billed code 99244 on 99203 indicating "The billed service does not meet the requirements of a consultation." The Claims Administrator denied reimbursement on the report code 99080 indicating "Reimbursement for this report is included with other services provided on the same day; therefore a separate payment is not warranted." The Claims Administrator denied reimbursement of billed code 99358 and 99354 indicating "Documentation provided does not justify the payment for a Prolonged Evaluation and Management service."

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.

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.

CPT 99354 - Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour.

Modifier 93 - Interpreter required at the time of examination. Prolonged service codes may not be used in combination with this modifier unless it is documented that the reason for the code is additional time required as a result of factors beyond the need for an interpreter.

Per a review of the CPT descriptions, the medical record must document and meet all three required components of an 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 selected the Provider as their Primary Treating Physician. The medical record documented a detailed history which included; chief complaint, extended history of present illness; problem pertinent review of systems (ROS); and pertinent past, family, and/or social history. The worker's current complaint/illness were documented as pain in the left wrist, forearm, low back, left hip and left knee. The presenting problems are considered low severity as the risk of morbidity and/or mortality without treatment is low. The medical record demonstrated a detailed examination of the following areas: bilateral upper and lower extremities and lumbar spine. The Provider's request for authorization included: physical therapy, acupuncture, prescription for Ibuprophen and Tramadol. 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. The medical record indicated the consultation was initiated by the injured worker. The Evaluation and Management service did not meet the requirements of a consultation. The Claims Administrator's code assignment of CPT 99203 was correct. The definition on 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 problems are of moderate severity." The Claims Administrator's

reimbursement did not include the additional allowance for Modifier 93. The Provider's report documented the examination was conducted with the assistance of an interpreter. Therefore, the additional allowance is due for the use of an interpreter.

The second disputed code is report code 99080. The Provider submitted a "Primary Treating Physician's Initial Comprehensive Report and Request for Authorization of Treatment" 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 is correct.

The third disputed code is the Prolonged Evaluation and Management service code 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 three hours of time spent on the following activities: review of diagnostic studies; research, review of ACOEM Guidelines and/or Mercy Guidelines. The report documented a review of the following; X-ray of the lumbar spine, left knee, left wrist, left hand and left hip. The report documented and referenced ACOEM guidelines and Title 8 California Code of Regulations. The report documented the reason for the code (99358) was additional time required as a result of factors beyond the need for an interpreter. The requirements of CPT 99358 were met based on the documentation submitted. The denial of CPT 99358 by the Claims Administrator was not correct.

The fourth disputed code is the Prolonged physician service code 99354. Per the OMFS Modifier 93 description, prolonged service codes may not be billed in combination with this modifier (93) unless it is documented that the additional time was required as a result of factors beyond the need of the interpreter. The report documented a total of two hours of time was spent with the worker taking history and performing an examination. The report did not document the additional time was required as a result of factors beyond the need for an interpreter. The denial of the billed code 99354 by the Claims Administrator was correct.

Based on the documentation submitted, an additional reimbursement of \$410.75 for Official Medical Fee Schedule code 99203 Modifier 93 and 99358 is warranted.

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

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99203	93		1	\$107.80	\$105.11	\$95.55	\$9.56	PPO Contract
99354			1	\$171.19	\$0.00	\$0.00	\$0.00	PPO Contract
99358			12	\$436.08	\$401.19	\$0.00	\$401.19	PPO Contract
99080			13	\$154.83	\$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 code 99358 and 99203 Modifier 93 (\$410.75) for a total of \$745.75.

The Claims Administrator is required to reimburse the provider \$745.75 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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