

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

1/7/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 2/20/2013 – 2/20/2013
MAXIMUS IBR Case: CB13-0000380

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/9/2013, 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 \$157.50, for a total of \$492.50.**

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 Evaluation and Management service (99215), and the denial of reimbursement for prolonged services (99354 and 99358) and a report code (99080) for date of service 2/20/2013. The Claims Administrator based the reimbursement of the billed procedure code 99215 on the procedure code 99203 with the explanation "Based on history this is the initial visit." The Claims Administrator denied the prolonged service code 99354 with the explanation "99354 prolonged services should be billed for additional face-to-face time beyond the usual services of the office visit. Based on the report it does not appear that patient contact beyond the usual service was performed." The Claims Administrator denied the prolonged service 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. Prep of report/review of your own records does not warrant this charge." The report procedure code 99080 was denied 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 CCR 9785 and is included in the E/M service."

CPT 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: Comprehensive history; Comprehensive examination; and Medical decision making of high complexity (typically 40 minutes). Usually, the presenting problem(s) are of moderate to high severity.

CPT 99203 - 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 (typically 30 minutes). Usually, the presenting problem(s) are of moderate severity.

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

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

The Provider submitted a report titled "Transfer of Care - Primary Treating Physician Initial Report." Based on a review of the report submitted by the Provider, the worker was seen by the Provider for an orthopedic evaluation. The worker's complaints were documented as low back pain and right leg pain. The medical record documented an expanded problem focused history which included; chief complaint, extended history of present illness (Duration, Location, Quality, Severity, and Modifying Factors); problem pertinent system review; and pertinent past, family and/or social history. The record did not document a Comprehensive History. The medical record demonstrated a detailed musculoskeletal examination of the following areas: lumbar spine and bilateral lower extremities. The medical record did not document all of the required elements of a comprehensive musculoskeletal examination as would be required of the Evaluation and Management procedure code 99215. The Provider reviewed an MRI from 2010 and current X-rays of the lumbar spine from 2/20/2013. The Provider recommended the following treatment: six week follow-up; Orthopedic surgical consultation; Medications (Vicodin and Zanaflex). The presenting problems are considered moderate severity, as the risk of morbidity without treatment is moderate. The medical decision making appears to be of low to moderate complexity due to the types of treatment recommended and management options discussed. The medical record did not meet the guidelines of a comprehensive history and exam or

medical decision making of high complexity. The code assignment and reimbursement of CPT 99203 by the Claims Administrator was correct.

The second disputed code is the prolonged services code 99354. Per the OMFS Information and Instructions Guidelines, when the physician is required to spend at least 30 minutes or more of direct (face-to-face) time in addition to the time set forth in the appropriate CPT, then CPT code 99354 may be charged in addition to the basic charge for the appropriate Evaluation and Management code. The report documented a total of two hours was spent with the patient that included taking a "comprehensive history and performing a comprehensive physical examination." The medical record supported the billed procedure code 99354. Reimbursement is warranted for the billed procedure code 99354.

The third disputed code is the prolonged evaluation and management services 99358. Prolonged service code (99358) may 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 medical record documented on the first page of the medical record, one hour of time spent on "Review of diagnostic studies and medical records and an "Additional one and half hours were spent in research, reviewing ACOEM Guidelines and/or Mercy Guidelines, and formulating opinion." Page six of the Provider's report indicated "No medical records were reviewed at the time of initial evaluation." This statement is inconsistent with the documentation of the review of records on the first page of the report. The medical record did not document or reference unusual or indepth research of the ACOEM and/or Mercy Guidelines. The medical record referenced the following ACOEM guidelines: Chapter 6, and pages 105-126, specifically pages 114 and 115 (prescribing of medications and referral to medical specialists). Due to the inconsistent documentation of medical records review and lack of documentation of ACOEM and Mercy Guidelines, the medical record did not indicate an additional two hours and thirty minutes of time was spent on care that was beyond the usual service involved in either the inpatient or outpatient setting.

The fourth disputed code is report code 99080. The Provider submitted a "Transfer of Care - Primary Treating Physician Initial 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.

The additional reimbursement of \$157.50 is warranted per the Official Medical Fee Schedule code 99354. There is no additional reimbursement warranted for the Official Medical Fee Schedule codes 99203, 99080 and 99354.

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

