

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Independent Bill Review Final Determination Upheld

7/28/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000403	Date of Injury:	4/29/2008
Claim Number:	[REDACTED]	Application Received:	8/27/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	4/17/2013 – 4/17/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99080, 99358 and 99086		

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/27/2014, 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

Supporting Analysis:

The dispute regards the denial of prolonged services (99358) and report services (99080 and 99086). The Claims Administrator denied the billed CPT 99080 with the following explanation "No additional reimbursement allowed after review of appeal/reconsideration. The criteria listed in the 4/1/99 OMFS. Please refer to the general instructions section, pages 5 and 6 section b. separately reimbursable treatment reports." The billed CPT code 99358 was denied with the following explanation "Per OMFS procedure code 99358, prolonged management service. (Reviewing extensive records tests, or in communication with other professionals). Based on the report, it appears this service was not done or does not substantiate a review of records." The billed CPT 99086 was denied with the following explanation "Duplicate chart note charge is payable when the payer (insurance carrier) requests an additional copy of the chart notes. The payer shall reimburse provider for the duplicate report. Request for duplicate chart notes is made only by the Claims Administrator."

- **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 fifteen minutes.
- **CPT 99086:** Reproduction of chart notes

The Provider submitted a document titled "Appeal to the Denial of our Request for Authorization for Five Sessions of Endovenous Laser Therapy, And 8 Sessions of Endovenous Chemical Ablation." The document submitted was an appeal letter. The letter was addressed to the Claims Adjuster and included a discussion and rationale for requested treatment. The report submitted did not meet the requirements or description of a separately reimbursable report as described in the OMFS General Information and Instructions Guidelines. The denial of the billed procedure code 99080 by the Claims Administrator was correct.

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 30 minutes of time spent on "compiling data, reviewing, dictating and editing the report." The report/appeal letter did not document the review was spent on activities described under the procedure code description of 99358. The Provider did not indicate the additional time was spent reviewing records or tests, job analysis, ergonomic status, work limitations or work capacity.

Based on the OMFS General Information and Instructions, request for chart notes shall be in writing and be made only by the Claims Administrator. A request for chart notes from the Claims Administrator was not submitted as part of the documentation. Reimbursement for CPT 99086 is not warranted.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99080, 99358 and 99086.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99080	4	\$240.00	\$0.00	\$0.00	\$0.00	OMFS
99358	2	\$100.00	\$0.00	\$0.00	\$0.00	OMFS
99086	3	\$90.00	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review (EOR) and comparison with OMFS Physician Services Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$0.00 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,

[Redacted signature]

[Redacted text]

[Redacted text]