

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

3/19/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/8/2013 – 4/8/2013
MAXIMUS IBR Case: CB13-0000473

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/12/2013, 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 denial of photos (99085), prolonged services (99358) and the payment amount for a report service (99080) performed on date of service 4/8/2013. The provider billed CPT 99085, CPT 99080 and CPT 99358, was reimbursed \$11.69 and is requesting additional reimbursement of \$478.31. The Claims Administrator reimbursed \$11.69 for CPT 99080 with the explanation "The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the schedule allowance." The Claims Administrator denied reimbursement on CPT 99085 with the explanation "No separate payment was made because the value of the service is included within the value of another service performed on the same day." The Claims Administrator denied reimbursement on CPT 99358 with the explanation "The charge was denied as the report/documentation does not indicate that the service was performed."

The following services were billed for date of service 4/8/2013:

CPT 99085 - Special external photography for documentation of significant medical progress or condition may warrant an additional charge.

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 99212 - Office or other outpatient visit for the evaluation and management of an established patient

CPT 99086 - Reproduction of chart notes

The Claims Administrator allowed reimbursement on CPT 99212 and 99080; and denied the billed CPT code 99085, 99086 and 99358. The Provider is disputing the payment amount of CPT 99080 and the denial of 99085 and 99358.

Per the OMFS the procedure code 99085 is listed as a "By Report" service. Procedures without unit values or "By Report" are defined as "Unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service." The documentation to support the "By Report" separate reimbursement was not submitted. Services such as "photos" are considered procedures that are commonly carried out as an integral part of a total service, and does not warrant separate reimbursement. The denial of procedure code 99085 by the Claims Administrator was correct.

The second disputed code is report code 99080. The Provider submitted a report titled "Comprehensive Dermatologic Re-evaluation Report, and Request for Authorization." A written request for a special report from the Claims Administrator was not submitted as part of the documentation. Based on the documentation submitted, a reimbursement allowance higher than the Claims Administrator's reimbursement of procedure code 99081 (Primary Treating Physician's Progress Report PR-2) could not be determined.

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 30 minutes of time spent on "reviewing records, compiling data, reviewing, dictating and editing the report." The report only documented the time spent on the record review and not the types or number of medical records or tests reviewed. There were no references or documentation within the report of a review of records or tests.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99085, 99080 and 99358.

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
99085	1	\$150.00	\$0.00	\$0.00	\$0.00	OMFS
99080	4	\$228.31	\$11.69	\$11.69	\$0.00	OMFS
99358	2	\$150.00	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS General Information and Instructions and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$11.69 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,

██████████, RHIT

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