MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Reversed

2/6/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 4/2/2013 – 4/2/2013
MAXIMUS IBR Case: CB13-0000483

Dear [redacted], MD:

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/11/2013, 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 $164.54, for a total of $499.54.**

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 office consulation services (99244) and denial of reimbursement for a consultation report (99080) and prolonged services (99358). The Claims Administrator based its reimbursement of billed CPT code 99244 on CPT code 99204 with the explanation "A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Based on the report, the service does not appear to be consultative in nature." The Claims Administrator denied the billed CPT 99080 with the explanation "Initial treatment reports and/or Doctor's first report of occupational illness or injury are not separately reimbursable per the OMFS, also preparation is included in the based medical service." The Claims Administrator denied the billed CPT code 99358 with the explanation "The 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."

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.
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.

The Provider submitted an "Initial Comprehensive Dermatologic Evaluation Report." The report was addressed to the Claims Administrator, and documented the worker was referred to the Provider for a dermatologic evaluation. The report documented the worker's history related to the dermatologic complaints and a physical examination. The Provider documented in the Current History, worker has been following up with another treating physician for liquid nitrogen treatments on face and arms and skin biopsies. Per the report, the Provider advised the worker of suspicious neoplasms on forehead and the worker will follow-up with the treating physician. The recommendations documented in the medical record consisted of: treatment of exisiting actinic keratosis; periodic dermatologic re-evaluations two to three times a year, suncreen and sun-protective hat. The Provider made recommendations for future medical care and treatment, but did not indicate care of the worker had been assumed at the time of the evaluation. Based on the documentation, it appears the evaluation met the OMFS requirements and definition of a consultation. Per the OMFS General Information and Instructions, A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. The documentation indicates the consultation was requested by an appropriate source (Claims Administrator). Therefore, reimbursement of 99204 by the Claims Administrator was not correct. The decription of CPT 99204 is "Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of moderate complexity." Reimbursement is warranted for the billed outpatient consultation code 99244.

The second disputed code is report code (99080). Per the OMFS General Information and Instructions, consultation reports (99080) are separately reimbursable when consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. The Evaluation and Management services submitted by the Provider

met the requirements of a consultation, therefore, reimbursement is warranted for the billed CPT code 99080 (6 units).

The report documented 45 minutes of time spent on "compiling data, reviewing, dictating and editing the report." The report 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.

The additional reimbursement of $164.54 is warranted per the Official Medical Fee Schedule codes 99244 and 99080. There is no additional reimbursement and/or allowance for the Official Medical Fee Schedule code 99358.

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 Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99244		1	$175.80	$157.13	$124.20	$32.93	PPO Contract
99080		6	$360.00	$131.61	$0.00	$131.61	PPO Contract
99358		3	$150.00	$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 codes 99244 and 99080 ($164.54) for a total of $499.54.

The Claims Administrator *is required to reimburse the provider $499.54 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,

[redacted], RHIT

Copy to:
[redacted]

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