

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

3/26/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 5/14/2013 – 5/14/2013
MAXIMUS IBR Case: CB13-0000500

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/6/2014, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$143.14, for a total of \$478.14.**

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: OMFS
- Other: OMFS Information and Instructions, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the payment amount of an Evaluation and Management service (99215 Modifier 17), report (99080) and denial of muscle testing services (95832 RT LT) performed on 5/14/2013. The Claims Administrator based its reimbursement of the billed procedure code 99215 on 99214 with the explanation "The Official Medical Fee Schedule does not list this code; an allowance has been made for a comparable service." The Claims Administrator based its reimbursement of the billed procedure code 99080 on 99081 with the explanation "The Official Medical Fee Schedule does not list this code; an allowance has been made for a comparable service." The Claims Administrator denied the billed procedure code 95832 RT LT with the explanation "Workers' Compensation Jurisdictional fee schedule adjustment."

CPT 99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of high 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 95832 - Muscle testing, manual (separate procedure); hand (with or without comparison with normal side).

Modifier 17 – To be used by the primary treating physician to identify a permanent and stationary evaluation and report.

The Provider submitted a Primary Treating Physician Permanent and Stationary Report (PR-4). The PR-4 documented an Evaluation and Management service performed on date of service 5/14/2013. The chief complaint was documented as "Weakness in the right arm." The medical record documented an expanded problem focused history which included; chief complaint, brief history of present illness; and problem pertinent system review (ROS). The medical record demonstrated a detailed musculoskeletal examination of the bilateral upper extremities. The report indicated the worker status as Permanent and Stationary, future medical care: anti-inflammatory medications; stellate blocks; cortisone injections and no further surgical treatment, and worker's impairment rating was documented.

The medical record did not illustrate the required components of the Evaluation and Management code 99215. The medical record met the requirements of the Evaluation and Management code 99214. The code assignment and reimbursement of CPT 99214 by the Claims Administrator was correct.

The second disputed code is the report code (99080). The Provider submitted a Permanent and Stationary evaluation and report (PR-4). Per the Official Medical Fee Schedule, to bill for the primary treating physician's permanent and stationary report, the physician shall select the appropriate Evaluation and Management code, if any, in accordance with Evaluation and Management guideline and the report code 99080. The Provider billed an Evaluation and Management code and the report code 99080 for the Permanent and Stationary evaluation and report. Reimbursement is warranted for the billed procedure code 99080 (6 units).

The narrative for CPT code 95832 includes a parenthetical statement that the procedure represents a "separate procedure". The inclusion of this statement indicates that the procedure can be performed separately but should not be reported when a related service is performed. The services described

by CPT 95832 are an integral part of the total service provided in the billed Evaluation and Management code. The CPT 95832 is bundled into CPT 99214.

The additional reimbursement of \$143.14 is warranted per the Official Medical Fee Schedule code 99080. There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99214 and 95832 RT LT.

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
99214	17	1	\$39.84	\$89.57	\$89.57	\$0.00	OMFS
99080		6	\$143.11	\$154.83	\$11.69	\$143.14	OMFS
95832	RT	1	\$46.74	\$0.00	\$0.00	\$0.00	OMFS
95832	LT	1	\$46.74	\$0.00	\$0.00	\$0.00	OMFS

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 99080 (\$143.14) for a total of \$478.14.

The Claims Administrator is required to reimburse the provider \$478.14 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,

██████████, RHIT

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