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

8/28/2014

[redacted]

IBR Case Number:	CB13-0000530	Date of Injury:	8/9/2005
Claim Number:	[redacted]	Application Received:	9/26/2013
Claims Administrator:	[redacted]		
Date(s) of service:	7/30/2013		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	95904, 95904 59, 99245, 99080, and 99358		

Dear [redacted]:

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/24/2014, 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 $1,168.72 for a total of $1,503.72.**

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: Official Medical Fee Schedule – Evaluation and Management, Surgery, Medicine, and Appendix Sections and Instructions.

Supporting Analysis:
Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

The dispute regards the payment for surgical facility services on date of service 7/30/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 95904, 95904 59, 99245, 99080, and 99358. The Claims Administrator reimbursed $483.78 for the following billed procedure code(s) noted. The Claims Administrator denied the billed procedure codes stated on EOBs, "95904 – The charge has been adjusted to OMFS; Included in another procedure; Distinct Procedural Service. ; 99245 – Submitted documentation does not support the level of service billed; Charge exceeds Fee Schedule allowance; Payer deems the information submitted does not support this level of service. ; 99080 – Charge exceeds Fee Schedule allowance; Charge exceeds fee schedule/maximum allowable or contracted/legislated fee agreement. ; 99358 – Charge exceeds Fee Schedule allowance; Charge exceeds fee schedule/maximum allowable or contracted/legislated fee agreement."

CPT 95904: Nerve conduction amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; motor without F-wave study; sensory.
CPT 99245: Office consultation for a new or established patient, which requires the three key components: a Comprehensive History; a Comprehensive Exam; and a Medical Decision Making of High Complexity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
CPT 99080: Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. Also to be used for separately reimbursable reports. (See instructions in "Reports" in the General Information and Instructions Section).
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 or ergonomic status, work limitations, work capacity, or communication with other professionals and/or the patient/family; each 15 minutes.
Modifier 59: Distinct Procedure

CPT 95904: Nerve conduction amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; motor without F-wave study; sensory. The Claims Administrator denied the billed CPT Code 95904 x 10 Units with statements in the EOB, "The charge has been adjusted to OMFS; Included in another procedure; Distinct Procedural Service". The Provider billed $1,612.60 with a Fee Schedule Adjustment of $1,128.82, Payment Amount of $483.48.

The Provider billed CPT Code 95903; however, this CPT Code was not part of the dispute. IBR comparison between the two CPT Codes 95903 vs. 95904 was to identify if 95903 was integral part of CPT Code 95904. CPT Code 95903 Nerve Conduction amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; **motor, with F-wave study**, where CPT Code 95904 Nerve Conduction amplitude and latency/velocity study, each nerve, any/all site(s) along the nerve; **sensory**. The Provider's Physical Medicine & Rehabilitation Med-Legal Evaluation and Electromyography / Nerve Conduction Studies report assessed only the **sensory** amplitude and latency/velocity studies of the specific body part. Therefore, the 95903 is a separate identified and billed procedure.

In comparison with the 2013 Current Procedural Terminology, Professional Edition, Appendix J, Guidelines with the Provider's Physical Medicine & Rehabilitation Med-Legal Evaluation and Electromyography / Nerve Conduction Studies report, it supports **each specific body part** assessment and documented based on the symptoms for the assessment referred by the PCP.

The specific body parts were assessed and documented in the medical record.

CPT Code 95904 x 20 Units:
Bilateral median (2 Units), radial (2 Units) and ulnar (2 Units) motor NCS revealed normal distal latency, normal conduction velocity and CMAP amplitude. Inter latency differences between ipsilateral median and ulnar distal latencies were normal.

Bilateral median (2 units), ulnar (2 Units) and radial (2 Units) antidromic sensory NCS revealed normal peak latencies and normal SNAP amplitudes. Inter latency difference between ipsilateral median and ulnar peak latencies were normal.

Bilateral medial and lateral antebrachial (4 Units) sensory CNS revealed normal peak latency and normal SNAP amplitude.

Bilateral median (2 Units) and ulnar (2 Units) F-waves showed normal minimum latencies.

The Current Procedural Terminology Guidelines, Appendix J, the Nerve Conduction Studies, CPT Code 95904, Motor NCS with and/or Without F Wave, supports this assessment of all 20 total number of nerve studies. The following chart below provides a reasonable maximum number of studies performed per diagnostic category necessary for a physician to arrive at a diagnosis in 90% of patients with that final diagnosis. The Provider documented and assessed for indications of Final Diagnoses' 722.0, 726.0, and 782.0. The numbers in each column represent the number of studies recommended. The appropriate number of studies to be performed is based upon the physician's discretion. The Provider assessed and documented a total of 20 Units of Motor NCS With and/or Without F Wave, Upper and Lower Extremities.

Type of Study/Maximum Number of Studies

Indication	Motor NCS With and/or Without F Wave
Radiculopathy 722.0 726.0	3
Pain, Numbness, or Tingling (Unilateral) 782.0	3
Pain, Numbness, or Tingling (Bilateral) 782.0	4

CPT 99245: Office consultation for a new or established patient, which requires the three key components: a Comprehensive History; a Comprehensive Exam; and a Medical Decision Making of High Complexity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

In OFMS Instructions, Evaluation and Management defines 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. When a consultation is requested, the initial evaluation by the consulting physician shall be billed as a consultation, even if the consultation results in the initiation of diagnostic and/or therapeutic services. The request for a consultation from the attending physician or other appropriate source and the need for consultation **must be documented** in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source. A consultation initiated by a patient and/or family, and not requested by a physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate.

Provider billed CPT Code 99245 - $468.36, 1 Unit disputing $238.79.
IBR identified **no documentation** within the medical record to support OFMS Consultation requirements.

IBR recommendation was however, supported by the documentation in meeting the Office or Other Outpatient Services, Evaluation and Management Service, New Patient.

99201 - OFMS Allowed Recommended Reimbursement: $39.90, 1 Unit

- Problem Focused History
- Problem Exam
- Straightforward

CPT 99080:
The OFMS General Information and Instructions defines a Separate Reimbursable Treatment Report where an office visit is included, the report charge is payable in addition to the underlying Evaluation and Management service for an office visit meeting the following reports criteria and content components.

- Primary Treating Physicians' Progress Reports, PR-2
- Final Treating Physicians' Report of Disability Status (DWC Form RU-90)
- Primary Treating Physicians' Final Discharge Report, PR-2
- Primary Treating Physicians' Permanent and Stationary Report
- Consultation Reports

IBR has not identified any reports meeting the OFMS report criteria and content requirements within the medical record to support the Provider billed CPT Code 99080 - $325.68, 6 Units disputing $154.83.

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 or ergonomic status, work limitations, work capacity, or communication with other professionals and/or the patient/family; each 15 minutes.
In the OFMS, General Information and Instructions, Prolong Services Codes: Where appropriate, a treating or consulting physician may be paid for service which extends beyond the usual service time for a particular Evaluation and Management code. The prolonged services code are of two types in the outpatient setting: direct (face-to-face) patient contact (CPT codes 99354 and 99355), and without direct (face-to-face) patient contact (CPT code 99358).

Where the physician is required to spend 15 or more minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other professionals, the CPT code 99358 may be charges in addition to the basic charge for the appropriate Evaluation and Management code.

CPT code 99358 may also be used where the physician is required to spend 15 or more minutes reviewing records or tests, a job analysis, an evaluation of ergonomic status, work limitations, or work capacity when there is **no direct (face-to-face) contact**; however, in this case the physician is **not entitled to charge and Evaluation and Management code**. For example, if subsequent to an examination of the employee, a consulting physician is asked to prepare a supplemental report based on a review of additional medical records, and the physician spends 15 minutes in this review, CPT code 99358 maybe be charged along with CPT code 99080 for a report, but no Evaluation and Management code may be charged.

IBR has not identified the time spent on record review or any other qualifying prolonged evaluation and management service to support the Provider billed CPT Code 99358 - $45.42, 1 Unit disputing $36.34.

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
95904		10	$322.52	$80.63 x10	$483.78	$322.52	OMFS
95904	59	10	$806.30	$80.63 x10	$0.00	$806.30	OMFS
99245		1	$238.79	$39.90	$0.00	$39.90	OMFS
99080		1	$154.83	$0.00	$0.00	$0.00	OMFS
99358		1	$36.34	$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 codes 95904, 95904 59, 99201 in lieu of 99245 **($1,168.72)** for a total of **$1,503.72**.

The Claims Administrator *is required to reimburse the provider* ***$1,503.72*** *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]**, MHA, BSN, CFE, CCS-P, CCS, CDC**

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