

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

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Independent Bill Review Final Determination Reversed

2/12/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/22/2013 – 4/22/2013
MAXIMUS IBR Case: CB13-0000551

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/28/2013, 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 \$285.18, for a total of \$620.18.**

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 an office consultation (99245), report (99080) and prolonged evaluation and management services (99358 x 5). The Claims Administrator based its reimbursement of billed code 99245 on 99243 indicating "After review of the bill and medical record, this service is best described by the code 99243." The Claims Administrator denied reimbursement on the report code 99080 indicating "The report is included in another procedure on this date of service." The Claims Administrator reimbursed one unit of 99358 with the explanation "Clinical validation reduction based upon review of documentation submitted."

CPT 99245 - Office consultation for a new or established patient, which requires 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 99243 - Office consultation for a new or established patient, which requires these three key components: Detailed history; Detailed examination; and Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity.

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.

Based on a review of the report submitted by the Provider, the worker was referred to the Provider for a psychiatric consultation. The medical record documented a detailed history which included; chief complaint, extended history of present illness; problem pertinent review of systems (ROS); and pertinent past, family, and/or social history. The medical record demonstrated a detailed psychiatric examination. The medical record did not document all of the elements required of a comprehensive history: Extended HPI; 10 system ROS; and complete PFSH. The medical record did not document all of the elements required of a complete psychiatric examination. The medical decision making was of low complexity due to the limited number of diagnosis and management options, moderate amount of data and record review, with low risk of complications and/or morbidity. The treatment recommendations were documented as future psychiatric treatment consisting of twenty sessions or more, utilization of appropriate psychoactive medication with psychiatric visits every one to three months indefinitely. The medical record did not demonstrate all of the required components of CPT 99245. Based on the documentation submitted, the Claims Administrator's reimbursement of CPT 99243 was correct.

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 consultation was requested for one or more medical issues by a party (Treating Physician/Claims Administrator). The Evaluation and Management services submitted by the Provider met the requirements of a consultation, therefore, reimbursement is warranted for the billed code 99080 (6 units). The Provider submitted an appeal letter dated 8/14/2013 to the Claims Administrator indicating the Provider was billing for a consultation report with a total of 15 pages. Per the OMFS General Information and Instructions, reimbursement of separately reimbursable reports is limited to six pages except by mutual agreement of the provider and payer. A written agreement between the Provider and Claims Administrator for reimbursement

