

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/5/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000649	Date of Injury:	7/30/2012
Claim Number:	[REDACTED]	Application Received:	10/25/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	4/8/2013 – 4/8/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215 Modifier 25, 17, 93, 99080, 99358 and 99070 (NDC 00781223310 and 00781118801)		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/3/2014, 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 \$62.62, for a total of \$397.62.**

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 General Information and Instructions

Supporting Analysis:

The dispute regards the denial of an Evaluation & Management code 99215 Modifier 17, 25, 93 and reimbursement for report services (99080), prolonged services (99358) and medications (99070). The Claims Administrator denied the billed code 99215 with the explanation "Only one patient management/office visit charge allowed per date of service." The Claims Administrator reimbursed \$147.09 for the billed procedure code 99080 with the explanation "The charge was adjusted to comply with the rate and rules of the contract indicated. The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance. Procedure is reimbursable when requested by carrier or self-insured employer." The Claims Administrator reimbursed \$69.05 for the billed procedure code 99358 with the explanation "The charge was adjusted to comply with the rate and rules of the contract indicated. The amount reflects a fee schedule reduction. The charge for this procedure exceeds the fee schedule allowance." The Claims Administrator reimbursed \$290.01 for the billed code 99070 (NDC 00781223310 and 00781118801) with the explanation "The charge was adjusted to comply with the rate and rules of the contract indicated. The amount paid reflects a fee schedule reduction."

- 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.
- 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 fifteen minutes.
- CPT 99070 - Supplies and materials
- Modifier 25 - Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service.
- Modifier 17 - This modifier is to be used by the primary treating physician to identify a permanent and stationary evaluation report.
- Modifier 93 - Interpreter required at the time of the examination: where this modifier is applicable the value of the procedure is modified by multiply the normal value by 1.1.

The Provider's dispute documented on the Independent Bill Review application, "The E/M code on this bill went unpaid and was incorrectly denied as being included in the report. It is not included in the pricing of the report (billed as 99080) as the EOR states. Per the OMFS the PTP's permanent and stationary report (denoted by modifier 17 on the report and E/M code) is payable in addition to the underlying evaluation and management service for an office visit."

Per a review of the disputed codes: 99080, 99358 and 99070 (NDC 00781223310 and 00781118801), it appears the services were reimbursed based on the Official Medical Fee Schedule minus a PPO discount. Per the Independent Bill Review application, the Provider did not indicate the PPO discount was in dispute; therefore, additional reimbursement is not recommended for the following codes: 99080, 99358 and 99070 (NDC 00781223310 and 00781118801).

The documentation submitted for review and evidence of services performed was a Primary Treating Physician's Permanent and Stationary Report (PR-4). The report documented an evaluation performed on 4/8/2013. Based on the documentation submitted, it did not appear there was another examination or service which included evaluation and management service performed on 4/8/2013 other than the documented Permanent and Stationary Evaluation billed as 99215 and 99080 by the Provider. Evaluation and Management services are separately reimbursable when billed with a Permanent and Stationary report code 99080; therefore, reimbursement is warranted for the evaluation and management services rendered.

Per a review of the medical record, reimbursement for the evaluation and management CPT code 99213 is recommended. The medical record demonstrated an expanded problem focused history, examination and medical decision making of low to moderate complexity. The interval history documented a prior injury to the left hand 7/30/2012 (phalanx fracture with possible tendon injury), and current complaint was documented as limited motion in left hand. The medical record documented a brief history of present illness, chief complaint and problem pertinent system review. An examination was performed on the upper right and left extremities. The use of a Spanish interpreter was documented in the record. Reimbursement is warranted for the Evaluation and Management code 99213 Modifier 93.

CPT 99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: expanded problem focused history; expanded problem focused examination; and medical decision making of low complexity

The PPO contract was not submitted as part of the documentation. The recommended allowance for the CPT 99213 Modifier 93 was calculated based on the OMFS Physicians Fee Schedule.

The additional reimbursement of \$62.62 is warranted per the Official Medical Fee Schedule code 99213 Modifier 93.

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
99213	17, 25, 93	1	\$142.35	\$62.62	\$0.00	\$62.62	OMFS
99080		6	\$162.51	\$147.09	\$147.09	\$0.00	PPO Contract
99358		2	\$76.31	\$69.05	\$69.05	\$0.00	PPO Contract
NDC 00781223310		60	\$239.95	\$217.35	\$217.35	\$0.00	PPO Contract
NDC 00781118801		60	\$79.84	\$72.66	\$72.66	\$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 code 99213 Modifiers 17,25,93 (\$62.62) for a total of \$397.62.

