

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Reversed**

5/2/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB13-0000711	Date of Injury:	11/24/2008
Claim Number:	[REDACTED]	Application Received:	11/8/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	4/16/2013 – 4/16/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99245 and 99080		

Dear [REDACTED]

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/6/2013, 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 \$147.09, for a total of \$482.09.**

**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 General Information and Instructions

**Supporting Analysis:**

The dispute regards the payment amount for an office consultation (99245) and report (99080). The Claims Administrator reimbursed \$125.04 for the billed procedure code 99245 with the explanation of "The document does not support the level of service billed. Reimbursement was made for a code supported by the description." The Claims Administrator denied the billed procedure code 99080 with the explanation "No separate payment was made because the value of the service is included within the value of another service performed on the same day."

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. 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.

The Provider submitted, as part of the documentation, a report titled "Psychiatric Consultation Report to Primary Treating Physician." The worker was referred by a treating physician to the Provider for a psychiatric consultation for the purposes of determining a diagnosis, treatment and other relevant issues. The documentation included a copy of the written certification for the "Psychiatric Consultation" from the Claims Administrator. Based on a review of the explanation of review, it appears the Claims Administrator based its reimbursement of the consultation services billed as CPT 99245 on CPT 99243.

Per a review of the CPT descriptions and guidelines, the medical record must document and meet all required components of the office consultation code.

The medical record documented a detailed history which included; chief complaint, extended history of present illness; extended pertinent review of systems (ROS); and pertinent past, family, and/or social history. The medical record did not demonstrate all of the elements required in a comprehensive psychiatric examination. The Provider's treatment recommendations indicated: no need for psychiatric treatment on an industrial basis; and treatment should continue through present mental health care provider. Due to the multiple number of diagnoses, minimal management options, moderate amount of data reviewed and low risk of complications and/or morbidity or mortality the medical decision making was of moderate complexity. The medical record did not demonstrate all the components for 99245. The Claims Administrator's code assignment and reimbursement of the consultation code 99243 was correct. The description of the CPT 99243 is "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 to high severity."

The second disputed service is the report code 99080. The Provider billed and was reimbursed for an office consultation code 99243. Per the Official Medical Fee Schedule General Information and Instructions, a report by a consulting physician is separately reimbursable using CPT 99080 where a consultation was requested on one or more medical issues by the treating physician, including second opinion on the medical necessity or appropriateness of a previously recommended medical treatment or surgical procedure. Based on the documentation submitted, the billed procedure code 99080 meets the OMFS definition and description of a separately reimbursable report due to: the consultation was requested by a treating physician for a psychiatric consultation for one or more medical issues. The Provider submitted a 10 page report and billed procedure code 99080. Based on

the OMFS General Information and Instructions, the maximum number of pages reimbursed for procedure code 99080 without prior authorization is six pages. Additional reimbursement is warranted per the billed procedure code 99080.

The additional reimbursement of \$147.09 is warranted per the Official Medical Fee Schedule code 99080. There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99245 (99243).

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99243	1	\$121.46	\$125.04	\$125.04	\$0.00	PPO Contract
99080	6	\$147.09	\$147.09	\$0.00	\$147.09	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 99080 (\$147.09) for a total of \$482.09.

***The Claims Administrator is required to reimburse the provider \$482.09 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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