

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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11/21/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/5/2013 – 3/5/2013
MAXIMUS IBR Case: CB13-0000106

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/20/2013, 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 upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

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
- Other: OMFS General Information and Instructions

Supporting Analysis:

The dispute regards the payment amount for an office consultation (99245 Modifier 93) and report (99080). The Provider billed CPT 99245 and 99080, was reimbursed \$152.69 and is requesting additional reimbursement of \$152.69. The Claims Administrator reimbursed \$152.69 for the billed procedure code 99245 indicating "The billed service does not meet the requirements of a consultation (see general information and instructions section of the physician's fee schedule)." The Claims Administrator denied the billed procedure code 99080 indicating "This report does not fall under the guidelines of a separately reimbursable report."

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 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

Modifier 93 - Interpreter required at the time of the examination.

Per a review of the CPT descriptions, the medical record must document and meet all three required components of office consultation code. The medical record did not demonstrate all the components for 99245.

Based on a review of the report submitted by the Provider, the worker was referred to the Provider by the Primary Treating Physician for an orthopedic consultation. The medical record documented an expanded problem focused history which included; chief complaint, history of present illness; and problem pertinent review of systems (ROS). The worker's current complaint/illness was a laceration to the dorsoulnar aspect of left fifth digit. The presenting problems are considered moderate severity as the risk of morbidity without treatment is moderate; uncertain prognosis or increased probability of prolonged functional impairment. The medical record demonstrated a detailed examination of the following areas: bilateral upper extremities. The Provider's recommendations included a wound exploration with extensor tendon repair. The medical record did not demonstrate all of the required elements of CPT 99245.

Per the OMFS General Information and Instructions, the referral for the transfer of the total or specific care of a patient from one physician to another does not constitute a consultation. A written request or authorization for the consult and/or treatment from the treating physician or Claims Administrator was not received as part of the documentation submitted. Based on the documentation submitted and the OMFS guidelines, the evaluation and management services did not meet the requirements and/or definition of a consultation.

Based on a review of the explanation of review (EOR) and payment, the Claims Administrator based its reimbursement of the billed code CPT 99245 Modifier 93 on CPT 99204 Modifier 93. The definition of CPT 99204 is "Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity." The Claims Administrator's reimbursement of CPT 99204 was correct.

The second disputed code is CPT 99080. The Provider submitted an "Initial Hand Surgical Consultation" report. The report submitted by the Provider is considered the initial treatment report

