

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

7/25/2014

██████████
██████████
██████████

IBR Case Number:	CB13-0000109	Date of Injury:	6/4/2010
Claim Number:	██████████	Application Received:	6/4/2013
Claims Administrator:	██████████		
Date(s) of service:	1/30/2013 – 1/30/2013		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	99244 Modifier 93		

Dear ██████████, MD:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/27/2014, 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 \$46.22, for a total of \$381.22.**

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 Evaluation and Management Guidelines, General Information and Instructions

Supporting Analysis:

The dispute regards the denial of reimbursement for an office consultation (99244 Modifier 93). The Claims Administrator denied the billed code with the explanation “The billed service does not meet the requirements of a consultation (See the General Information and Instructions Section of the Physician’s Fee Schedule). A consultation code is only allowed for the initial visit. Subsequent visits must be billed using CPT codes 99211-99215. Please resubmit with the correct CPT code.”

CPT 99244 - Office consultation for a new or established 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. Modifier 93 – Interpreter required at the time of the examination; where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.1.

Per a review of the CPT descriptions, the medical record must document and meet all three required components of an office consultation code. The medical record did not demonstrate all the components for 99244.

Based on a review of the report submitted by the Provider, the worker was seen for a follow-up psychiatric consultation. The report documented the patient was seen with the assistance of a Spanish speaking interpreter. The medical record documented the history which included; list of current psychiatric complaints; problem focused history and exam. The Provider's treatment plan included: Prozac 20 mg, Ativan 1 mg, Norco, and a follow-up visit in 12 weeks. The medical record did not demonstrate all of the required elements of CPT 99244. The evaluation and management services met the requirements and description of CPT 99212 Modifier 93. The description of CPT 99212 is “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: problem focused history; problem focused examination; and straightforward medical decision making.”

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 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. The visit was described as a follow-up visit and provider prescribed medications and a follow-up visit. The Provider is a treating physician; therefore, the services provided do not meet the requirements or definition of a consultation. Reimbursement is warranted for the evaluation and management services based on CPT 99212.

The additional reimbursement of \$46.22 is warranted per the Official Medical Fee Schedule code 99212 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
99212	93	1	\$203.35	\$46.22	\$0.00	\$46.22	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 code 99212 Modifier 93 (\$46.22) for a total of \$381.22.

The Claims Administrator is required to reimburse the provider \$381.22 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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