

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review

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8/27/2013

Independent Bill Review Final Determination Reversed

[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/31/2013 – 1/31/2013
MAXIMUS IBR Case: CB13-0000117

Dear [REDACTED] MD,

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 6/28/2013, 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 \$66.86, for a total of \$401.86.**

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 denial of chart reproduction services, photos, prolonged Evaluation and Management services and the amount paid for a report completed on 1/31/2013. The provider billed CPT 99086, CPT 99085, CPT 99358 and CPT 99080, was reimbursed \$10.75 and is requesting additional reimbursement of \$509.25. The Claims Administrator reimbursed \$10.75 for CPT 99080 indicating "The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service." The Claims Administrator denied reimbursement on CPT 99085 and CPT 99086 indicating "Missing/incomplete support data for bill." The Claims Administrator denied reimbursement on CPT 99358 indicating "Charge for a separate procedure, that does not meet the criteria for payment. See the OMFS General Instructions for Separate Procedures rule."

The Provider billed the following procedures for date of service 1/31/13:

CPT 99212 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.

CPT 99358 - Prolonged evaluation and management service before and/or after direct patient care.

CPT 99086 - Reproduction of chart notes.

CPT 99085 - Special external photography for documentation of significant medical progress or condition may warrant an additional charge.

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

The Provider billed for CPT Evaluation and Management code 99212 and Prolonged Service code 99358. Per the OMFS General Information and Instructions, where the physician is required to spend 15 minutes before and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other professionals, the CPT code 99358 may be charged in addition to the basic charge for the appropriate Evaluation and Management code. The report, for date of service 1/31/2013 submitted by the Provider, indicated the Provider spent thirty minutes on record review. The total time spent on record review was documented on the last page of the report. Based on the documentation submitted reimbursement for CPT 99358 is warranted.

The second disputed code is CPT 99086 "Chart Notes." Based on the OMFS General Information and Instructions, request for chart notes shall be in writing and be made only by the Claims Administrator. A request for chart notes from the Claims Administrator was not submitted as part of the documentation. Reimbursement for CPT 99086 is not warranted.

The third disputed code is the charges for photos billed as CPT 99085. Per the OMFS the procedure code 99085 is listed as a "By Report" service. Procedures without unit values or "By Report" are defined as "Unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service." The documentation to support the "By Report" separate reimbursement was not submitted. Services such as "photos" are considered procedures that are commonly carried out as an integral part of a total service, and does not warrant separate reimbursement. The denial of procedure code 99085 by the Claims Administrator was appropriate.

The fourth disputed billed procedure code is CPT 99080. The Provider submitted a report titled Comprehensive Dermatologic Re-evaluation Report, and Request for Authorization for Follow-up Visits and Treatment. The Provider is the Primary Treating Physician. The contents of the report are consistent with the description and requirements of a Primary Treating Progress Report (PR-2). Per review of the OMFS General Information and Instructions under the Reports section, CPT 99081 is used when billing for Primary Treating Physician's Progress Reports. The code assignment and reimbursement of CPT 99081 by the Claims Administrator was appropriate.

Based on the documentation submitted an additional allowance for the disputed codes CPT 99086, CPT 99085 and CPT 99081 is not warranted. The requirements of CPT 99358 were met based on the documentation submitted by the Provider. Therefore, the denial of CPT 99358 by the Claims Administrator was inappropriate.

The additional reimbursement of \$66.86 for CPT 99358 is warranted based on the following calculation:

PPO Allowance CPT 99358 (each 15 minutes) = \$33.43
 Total time billed 30 minutes = 2 units
 \$33.43 X 2 (units) = \$66.86

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

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99358			2	\$100.00	\$66.86	\$0.00	\$66.86	PPO Contract
99086			3	\$90.00	\$0.00	\$0.00	\$0.00	PPO Contract
99085			1	\$150.00	\$0.00	\$0.00	\$0.00	PPO Contract
99081			1	\$169.25	\$10.75	\$10.75	\$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 99358 (\$66.86) for a total of \$401.86.

The Claims Administrator is required to reimburse the provider \$401.86 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

Copy to:



Copy to:

Division of Workers' Compensation Medical Unit
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