

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

8/27/2013

Independent Bill Review Final Determination Reversed

[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 2/8/2013 – 2/8/2013
MAXIMUS IBR Case: CB13-0000130

Dear [REDACTED],

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 \$56.93, for a total of \$391.93.**

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 Information and Instructions Guidelines

Supporting Analysis:

The dispute regards the denial of Office Consultation services and a Consultation Report completed for date of service 2/8/2013. The Provider billed CPT 99244 and CPT 99080 and is requesting reimbursement of \$339.69. The Claims Administrator denied CPT 99244 indicating "Procedure code billing restricted/once per day. The billed service does not meet the requirements of a Consultation." The Claims Administrator denied CPT 99080 indicating "Report is included with other services provided on the same day; therefore a separate payment is not warranted."

The provider billed the following services for date of service 2/8/2013:

CPT 99244 - Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.

CPT 99354 - Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service.

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

CPT 90862 - Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

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

The Claims Administrator allowed reimbursement on the prolonged service code 99354. Prolonged service with direct patient contact is reported in addition to the designated Evaluation and Management service at any level.

Based on a review of the documents submitted, the Provider did not demonstrate that the Evaluation and Management services met the requirements of Office Consultation code 99244. The worker was referred to the Provider by the Primary Treating Physician for an evaluation and opinion in regards to the origin of the worker's current psychiatric complaints. The Provider prescribed medication and requested a follow-up visit. Per the OMFS Information and Instructions, the referral for the transfer of the total care or specific care of a patient from one physician to another does not constitute a consultation. The reimbursement of CPT 99244 is not warranted. Based on the review of the medical record the criteria of CPT 99213 was met.

The description of CPT 99213 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity.

Expanded problem focused history is defined as meeting the requirements of or documenting the chief complaint, a brief history of present illness and problem pertinent system review. The patient's chief complaint was documented, duration of complaint, associated signs and symptoms of illness were discussed as well as a review of the body system directly related to the chief complaint. The Provider documented an examination of the affected body system. The Provider prescribed medications and reviewed the Primary Treating Physician's Initial report. The medical decision making appears to be of low complexity.

The second disputed code is CPT 99080. The Provider submitted a report titled Report of Psychiatric Consultation. The report submitted was addressed to the Primary Treating Physician. The Provider

prescribed medication and requested a follow-up visit, therefore, is considered a Secondary Treating Physician to the worker. Per the OMFS Information and Instructions Guidelines, reports submitted by the Secondary Physician to the Primary Treating Physician are not reimbursable.

The documentation submitted warranted reimbursement of the Evaluation and Management services. The denial of the report code 99080 by the Claims Administrator was appropriate. The criteria of 99213 was met based on the review of the medical record for date of service 2/8/2013.

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
99213			1	\$184.86	\$56.93	\$0.00	\$56.93	OMFS
99080			1	\$154.83	\$0.00	\$0.00	\$0.00	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 99213 (\$56.93) for a total of \$391.93.

The Claims Administrator is required to reimburse the provider \$391.93 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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Oakland, CA 94612