

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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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: 3/5/2013 – 3/5/2013
MAXIMUS IBR Case: CB13-0000131

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 \$157.49, for a total of \$492.49.**

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 amount paid for Evaluation and Management and Prolonged Evaluation and Management services on date of service 3/5/2013. The Provider billed CPT 99215 and CPT 99354, was reimbursed \$82.40 and is requesting additional reimbursement of \$218.20. The Claims Administrator down coded the billed code 99215 to 99214 indicating "The documentation did not support the level of service billed. Reimbursement was made for a code that is supported by the documentation submitted with the billing. Procedure 99214 is recommended." The Claims Administrator denied reimbursement for CPT 99354 indicating "Prolonged E/M service not justified/documented."

The description of CPT 99215 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: A comprehensive history; A comprehensive examination; Medical decision making of high complexity." The description of CPT 99214 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: A detailed history; A detailed examination; Medical decision making of moderate complexity."

Based on a review of the documentation submitted, the Provider did not demonstrate that the Evaluation and Management services met the required components of 99215. The documentation submitted met the criteria described in CPT 99214.

The medical record documented the chief complaint, pertinent history and detailed description of the current complaints. The Provider documented an examination of the affected body areas: cervical and lumbar spine, upper extremities, and lower extremities. The Provider reviewed x-rays of the cervical spine, right wrist and pelvis. The Provider requested authorization for a follow-up visit, continued psychiatric visits and a follow-up visit with an orthopedic physician. The medical decision making appears to be of low complexity.

The second disputed code is CPT 99354. The description of CPT 99354 is "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour." Prolonged service with direct patient contact is reported in addition to the designated Evaluation and Management service at any level. Per the OMFS General Information and Instructions, where the physician is required to spend at least 30 minutes or more of direct (face-to-face) time in addition to the time set forth in the appropriate CPT code, then CPT 99354 may be charged in addition to the charge for the appropriate Evaluation and Management code. The report documented a total of 1 hour and 45 minutes of time spent with the worker. Based on the documentation submitted additional reimbursement of 99354 is warranted.

The code assignment of CPT 99214 by the Claims Administrator was appropriate. The CPT 99354 requirements were met based on the documentation submitted by the Provider. The denial of CPT 99354 by the Provider was not appropriate. The additional reimbursement of \$157.49 for CPT 99354 is warranted based on the following calculation:

PPO Contract Allowance CPT 99354 \$157.49
Provider Billed 99354 X 1 (units)
Total recommended allowance \$157.49

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
99214			1	\$47.01	\$82.40	\$82.40	\$0.00	PPO Contract
99354			1	\$171.19	\$157.49	\$0.00	\$157.49	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 99354 (\$157.49) for a total of \$492.49.

The Claims Administrator is required to reimburse the provider \$492.49 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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