

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

8/1/2014

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IBR Case Number:	CB13-0000158	Date of Injury:	5/6/2008
Claim Number:	██████████	Application Received:	6/17/2013
Claims Administrator:	██		
Date(s) of service:	1/21/2013 – 1/21/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	99244, 99354, 99358, 99080		

Dear ██████████

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 \$157.50, for a total of \$492.50.**

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 reimbursement for an office consultation (99244), prolonged services (99354 and 99358) and report (99080). The Claims Administrator based its reimbursement of the billed code 99244 on CPT 99204 with the following explanation "Code 99204 was recommended in lieu of 99244 as it appears the provider has assumed care of patient and is not acting as a consultant, therefore as an initial visit the report is not reimbursable." The Claims Administrator denied the billed code 99354 with the explanation "99354 prolonged services should be billed for additional face-to-face time beyond the usual services of the office visit. Based on the report it does not appear that patient contact beyond the usual service was performed." The Claims Administrator denied the billed code 99358 with the explanation "Review of providers charts, MRI, testing, etc. is an integral part of E/M process and is not beyond the usual service in outpatient setting per OMFS pg. 70; this is performed in order to aid the physician in diagnosing the patient and is included in E/M." The Claims Administrator denied the billed code 99080 with the explanation "Per OMFS this classifies as an initial report and as such is inclusive within the value of the initial visit. No allowance can be made for this service."

- 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.
- CPT 99354 - Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour.
- CPT 99358 - Prolonged Evaluation and Management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records, job analysis, evaluation of ergonomic status, work limitations, work capacity, or communication with other professionals and/or the patient/family); each fifteen minutes.
- CPT 99080 - Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

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. Per the documentation, the injured worker was referred to the Provider by his Primary Treating Physician. Treatment plan included a follow-up visit in four weeks, and prescription for Ativan, Ambien and Wellbutrin. The Provider appears to be a treating physician; therefore, the services provided do not meet the requirements or definition of a consultation.

The Claims Administrator reimbursed the Provider for CPT 99204. Based on a review of the medical record and OMFS Evaluation and Management guidelines, reimbursement for a higher level E&M CPT code is not recommended. The description 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."

Per the OMFS General Information and Instructions, the following reports are not separately reimbursable: initial treatment report and plan; and reports by a secondary physician to the primary treating physician. The report submitted as part of the documentation was an initial consultation

report. The injured worker was referred to the Provider by the Primary Treating Physician. The provider is considered a secondary treating physician and the report was an initial treatment report and plan. No additional reimbursement is recommended for the billed procedure code 99080.

The third disputed code is the prolonged services code 99354. Per the OMFS Information and Instructions Guidelines, when 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, then CPT code 99354 may be charged in addition to the basic charge for the appropriate Evaluation and Management code. The report documented a total of 1.5 hours was spent with the patient that included taking a "history and performing a comprehensive mental status examination." The time included in the reimbursed Evaluation and Management CPT Code 99204 is forty-five minutes. The Provider documented additional forty-five minutes of face-to-face time with the injured worker beyond the time set-forth in the Evaluation & Management code 99204. The medical record supported the billed CPT code 99354. Reimbursement is warranted for the billed procedure code 99354.

The fourth disputed code is the prolonged evaluation and management service code 99358. Prolonged service code (99358) may be used when the physician is required to spend 15 or more minutes reviewing records or tests, a job analysis, and evaluation of ergonomic status, work limitations, or work capacity when there is no direct (face-to-face) contact. The report documented "an additional 2.5 hours was spent reviewing medical records and preparing this report." Time spent on report preparation is not listed as a "prolonged service" activity billable under CPT 99358. The report listed a review of the "Primary Treating Physician's Permanent and Stationary Report" from December 4, 2012. Record review is included in the prolonged services billable under CPT 99358; however, based on the documentation it is not clear how much time was spent on the record review. Therefore, the reviewers were unable to recommend reimbursement for the billed CPT code 99358.

The additional reimbursement of \$157.50 is warranted per the Official Medical Fee Schedule code 99354.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99204	1	\$50.43	\$134.43	\$134.43	\$0.00	PPO Contract
99354	1	\$171.19	\$157.50	\$0.00	\$157.50	PPO Contract
99358	10	\$363.40	\$0.00	\$0.00	\$0.00	PPO Contract
99080	6	\$154.83	\$0.00	\$0.00	\$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 code 99354 (\$157.50) for a total of \$492.50.

The Claims Administrator is required to reimburse the provider \$492.50 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,

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