

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

3/24/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/11/2013 – 3/11/2013
MAXIMUS IBR Case: CB13-0000178

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/26/2013, 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 \$207.98, for a total of \$542.98.**

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, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the denial of an Evaluation and Management service (99215 Modifier 93) and prolonged services (99358) performed on date of service 3/11/2013. The Claims Administrator denied the billed procedure codes 99215 and 99358 with the explanation “We cannot review this service without a copy of the necessary documentation. Please resubmit with the indicated documentation as soon as possible. This charge was disallowed as additional information/definition is required to clarify service(s) rendered.”

CPT 99215 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of high complexity. Usually the presenting problem(s) are of moderate to high severity.

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.

Modifier 93 – Interpreter required at the time of examination: Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.1. Prolonged service codes may not be used in combination with this modifier unless it is documented that the reason for the code is additional time required as a result of factors beyond the need for an interpreter.

The Provider submitted a Primary Treating Physician’s Report (PR-2). The report was billed with procedure code 99081, and was reimbursed by the Claims Administrator for the billed procedure code 99081. The Evaluation and Management services and documentation of prolonged services were documented on the PR-2.

The documentation included a Primary Treating Physician’s Progress Report (PR-2). The PR-2 documented an evaluation and management service performed on date of service 3/11/2013. The subjective complaints were documented as “pain in neck which radiates down the arms with numbness.” The medical record documented an expanded problem focused history which included; chief complaint, brief history of present illness; and problem pertinent system review (ROS). The medical record demonstrated an expanded problem focused musculoskeletal examination of the affected body areas: upper extremities; and cervical spine. The Provider recommended: repeat cervical MRI; continued anti-inflammatory medications; and follow-up examinations. The Medical decision making was of low complexity due to the limited number of diagnoses and management options; limited amount of data reviewed; and low risk of complications and/or morbidity and mortality. Based on the documentation submitted and the OMFS guidelines, the evaluation and management services did not meet the requirements and/or definition of procedure code 99215. The medical record illustrated two of the three requirement components (low complexity medical decision making, expanded problem focused history and examination) of the Evaluation and Management code 99213. The description of CPT 99213 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: expanded problem focused history; expanded problem focused examination; and medical decision making of low complexity. Usually the presenting problem(s) are of low severity. Reimbursement is warranted based on the Evaluation and Management service (99213). The Provider's report documented the examination was conducted with the assistance of a Spanish-English interpreter. Therefore, the additional allowance is due for the use of an interpreter.

The third disputed code is the Prolonged Evaluation and Management service code 99358. Based on a review of the OMFS General Information and Instructions, Prolonged Evaluation and Management Service (99358) is used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual service in either the inpatient or outpatient setting. The prolonged service code (99358) may also 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 one hour of time spent reviewing a QME report. The report documented the reason for the code (99358) was additional time required as a result of factors beyond the need for an interpreter. The requirements of CPT 99358 were met based on the documentation submitted.

The additional reimbursement of \$207.98 is warranted per the Official Medical Fee Schedule codes 99213 Modifier 93 and 99358.

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
99213	93	1	\$141.98	\$62.62	\$0.00	\$62.62	OMFS
99358		4	\$145.36	\$145.36	\$0.00	\$145.36	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 codes 99358 and 99213 Modifier 93 (\$207.98) for a total of \$542.98.

The Claims Administrator is required to reimburse the provider \$542.98 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:

[Redacted]