

Supporting Analysis:

The dispute regards the denial for Prolonged services (99358 Modifier 24) and Report Code (99080-24) on date of service 02/21/2013. The Provider billed CPT 99358 and CPT 99080 and is requesting reimbursement of \$139.35. The Claims Administrator denied reimbursement of 99358 with the explanation "Medical documentation does not support services rendered." The Claims Administrator reimbursed \$37.22 for one unit of billed procedure code 99080 and denied the second unit of the billed procedure code 99080 with the explanation "The report does not fall under the fee schedule guidelines of a reimbursable report."

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 professional and/or the patient/family); each 15 minutes.

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

Modifier 24 - Unrelated evaluation and management service by the same physician during a postoperative period.

The Provider submitted a report titled "Primary Treating Physician Report of Prolonged Services, Phone Call and Appeal of Denied Treatment." The report documented a review of records and utilization review documents, and recommendations: additional therapy; additional pain medications; updated cervical MRI; updated upper extremities nerve tests; and additional Provider Consultations. The report also indicated that an updated treatment plan would be submitted at a later date. A written request from the Claims Administrator for a special report (99080) was not received as part of the documentation. Per the OMFS General Information and Instructions, " the Primary Treating Physician Progress Report is reported using CPT 99081 and separately reimbursable when there is any significant change in the treatment plan reported in the doctor's first report including, but not limited to, an extension of duration or frequency of treatment, a new need for hospitalization or surgery, a new need for referral to or consultation by another physician, a change in methods of treatment or in required physical medicine services, a need for rental or purchase of durable medical equipment or orthotic device. The report documented a need for additional physical therapy, pain medication and new consultation. Based on the submitted report, it appears the report meets the definition and requirements of a Primary Treating Physician's Progress report (99081). The Claims Administrator's reimbursement of \$37.22 for the billed procedure code 99080 is higher than the OMFS allowance for procedure code 99081; therefore, no additional reimbursement is warranted for the report.

The second disputed code is the prolonged services 99358. Prolonged Evaluation and Management codes are reimbursable when the Provider is required to spend 15 or more minutes before and/or after without direct face-to-face patient contact in reviewing extensive records, tests or in communication with other professionals. The Provider documented in the beginning of the report 45 minutes of time spent on outside record review: laboratory results; Claims Administrator utilization review correspondences; and physical therapy records. Based on the submitted documentation reimbursement is warranted for three units of billed procedure code 99358.

The additional reimbursement of \$106.84 is warranted per the Official Medical Fee Schedule Code 99358. There is no additional reimbursement warranted per the Official Medical Fee Schedule code 99080.

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
99080	24	1	\$24.60	\$11.45	\$37.22	\$0.00	PPO Contract
99358	24	3	\$114.75	\$106.84	\$0.00	\$106.84	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 99358 Modifier 24 (\$106.84) for a total of \$441.84.

*The Claims Administrator is required to reimburse the provider \$441.84 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:

██
██
██