

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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11/25/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 2/12/2013 – 2/12/2013
MAXIMUS IBR Case: CB13-0000280

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/20/2013, 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 upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

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
- Other: OMFS Information and Instructions, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the payment amount for an office consultation (99244), report (99080) and prolonged evaluation and management services (99358). The Claims Administrator based its reimbursement of billed code 99244 on 99203 indicating "The above code has been recommended in lieu of 99244 as it appears the provider has assumed care of the patient and is not acting as a consultant. The assigned code best describes services rendered per CA fee schedule." The Claims Administrator denied reimbursement on the report code 99080 indicating "The billing reflects procedure 99080 special reports. Per OMFS, no allowance is made for standard treatment reports as this is a requirement of the treating physician, as stated in California Code Regulations (ccr9785) and is included in the E/M service." The Claims Administrator denied reimbursement of billed code 99358 indicating "Per OMFS 99358, prolonged management service, is for reviewing extensive outside records, tests or in communication with other professionals. Per report OMFS guidelines were not met. Preparation of report/review of your own records does not warrant this charge."

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

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 15 minutes.

Per a review of the CPT descriptions, the medical record must document and meet all three required components of an office consultation code. The medical record did not demonstrate all the components for 99244.

Based on a review of the report submitted by the Provider, the worker was referred to the Provider for a dermatological consultation. The medical record documented the history which included; chief complaint, extended history of present illness; problem pertinent review of systems (ROS); and pertinent past, family, and/or social history. The worker's current complaint/illness was documented as skin cancer. The medical record documented the following diagnoses: history of basal cell carcinoma left neck, resolved; actinic keratosis; actinic cheilitis; and four neoplasms of undetermined origin rule out carcinoma. The presenting problems are considered moderate severity as the risk of morbidity and/or mortality without treatment is moderate. The medical record demonstrated a detailed dermatological examination of the following areas: head, neck and upper extremities. The Provider's request for authorization included: future evaluations, follow-ups, cryosurgery, and skin biopsy. The medical record did not demonstrate all of the required elements of CPT 99244.

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 letter from the worker's attorney dated 1/31/2013, requested the Provider "treat the applicant in the specialty of dermatology." The referral indicated the need for treatment, therefore, the initial visit does not meet the OMFS guidelines of a consultation. The Claims Administrator's reimbursement of CPT 99203 was correct. The definition on CPT 99203 is "Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: Detailed history; Detailed examination; and Medical decision making of low complexity. Usually, the presenting problems are of moderate severity."

The second disputed code is report code 99080. The Provider submitted an "Initial Comprehensive Dermatologic Evaluation Report and Request for Authorization" report. The report submitted by the Provider is considered the initial treatment report and plan. Per the OMFS General Information and Instructions, the initial treatment report and plan is not a separately reimbursable report. The denial of CPT 99080 by the Claims Administrator is correct.

The third disputed code is the prolonged evaluation and management services (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 45 minutes of time spent on "compiling data, reviewing, dictating and editing the report." The report did not document the review was spent on activities described under the procedure code description of 99358. The Provider did not indicate the additional time was spent reviewing records or tests, job analysis, ergonomic status, work limitations or work capacity.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99203, 99080 and 99358.

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
99203			1	\$300.00	\$88.28	\$0.00	\$0.00	PPO Contract
99080			6	\$360.00	\$0.00	\$0.00	\$0.00	PPO Contract
99358			3	\$150.00	\$0.00	\$0.00	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Information and Instructions, Evaluation and Management Guidelines and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$88.28 is upheld.

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,

[REDACTED], RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]