

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

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10/17/2013

**Independent Bill Review Final Determination Reversed**

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 1/22/2013 – 1/22/2013  
MAXIMUS IBR Case: CB13-0000281

Dear [REDACTED], MD:

**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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$123.56, for a total of \$458.56.**

**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 payment amount for an office consultation (99244), prolonged evaluation and management services (99358), chart notes (99086) and a report (99080). 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 California Fee Schedule." 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." The Claims Administrator denied reimbursement on billed code 99080 indicating "The billing reflects procedure code 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 and is included in the E/M service."

The Provider billed the following services on date of service 1/22/2013:

CPT 99244 - Office consultation for a new or established patient, which requires these three components: Comprehensive history; Comprehensive examination; and Medical decision making of moderate complexity (typically 60 minutes). 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 15 minutes.

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

CPT 99086 - Reproduction of chart notes.

Based on a review of the documents submitted, the Provider did not demonstrate that the Evaluation and Management services met the requirements of Office Consultation code 99244. The Provider submitted a report titled "Initial Comprehensive Dermatologic Evaluation Report, and Request for Authorization for Follow-up Visits and Treatment." The Provider requested authorization for future evaluations, follow-up visits, treatment for the patient's condition (liquid nitrogen for the actinic keratoses and skin biopsies). 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. The code assignment of CPT 99203 by the Claims Administrator was appropriate. The description of 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 (typically 30 minutes). Usually the presenting problem(s) are of moderate severity."

The second disputed code is CPT 99358. Per the OMFS Evaluation and Management guidelines, code 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 report documented 60 minutes of time spent reviewing records, compiling data, reviewing, dictating and report review. The Provider documented and billed for 4 units of CPT 99358. The denial of CPT 99358 by the Claims Administrator was not appropriate.

The third disputed code is CPT 99086. Per the OMFS Information and Instructions, chart note requests shall be made only by the Claims Administrator. A letter from the Claims Administrator requesting chart notes was not submitted as part of the documentation. Therefore, the denial of CPT 99086 by the Claims Administrator was appropriate.

The fourth disputed code is CPT 99080. The Provider submitted an Initial Treatment Report and Plan. Per the OMFS Treatment Report guidelines, the initial treatment report is not separately reimbursable. The appropriate fee is included within the underlying Evaluation and Management service for an office visit (99201-99215). The denial of CPT 99080 by the Claims Administrator was appropriate.

Based on the review of the submitted documentation, reimbursement of \$123.56 is warranted for Original Medical Fee Schedule code 99358. The documentation submitted did not support additional reimbursement of the billed codes 99244, 99080 and 99086.

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	\$211.72	\$88.28	\$88.28	\$0.00	PPO Contract
99358			4	\$200.00	\$123.56	\$0.00	\$123.56	PPO Contract
99086			3	\$90.00	\$0.00	\$0.00	\$0.00	PPO Contract
99080			6	\$360.00	\$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 99358 (\$123.56) for a total of \$458.56.

***The Claims Administrator is required to reimburse the provider \$458.56 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,

[REDACTED], RHIT

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

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