

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280

9/3/2013

Independent Bill Review Final Determination Reversed

[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/8/2013 – 1/8/2013
MAXIMUS IBR Case: CB13-0000040

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 7/2/2013, 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 \$154.07, for a total of \$489.07.**

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: AMA CPT Evaluation and Management Guidelines and OMFS General Information and Instructions

Supporting Analysis:

The dispute regards the amount paid for Evaluation and Management services, Prolonged Evaluation and Management Services and a report. The provider billed CPT 99214 Modifier 57, CPT 99354 and CPT 99080 Modifier 18, was reimbursed \$61.76 and is requesting additional reimbursement of \$307.09. The Claims Administrator down coded the billed CPT 99214 to CPT 99213 indicating "Based on the attached documentation, the history is expanded, the examination is expanded, and the medical decision-making appears to be of low complexity. In this instance procedure 99213 appears more appropriate." The Claims Administrator denied reimbursement for CPT 99354 indicating "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 based its reimbursement on CPT 99081, for the billed CPT 99080, indicating "99080 was recommended as code 99081 based on the description set by the OMFS. Per CCR 9785, progress reports, can be reported in a DWC form PR-2 or equivalent. According to pg. 6 of the OMFS, 99081 should be used for progress, interim, or supplemental reports."

The Description of CPT 99213 is an office or other outpatient visit for the evaluation and management of an established patient, which includes: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient and/or family needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

The description of CPT 99214 is an office or other outpatient visit for the evaluation and management of an established patient, which includes: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patients and/or family needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

The description of Modifier 57 is "Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

The medical report submitted documented a level three office visit (99213). The history documented included the chief complaint (left shoulder pain), review of one system (musculoskeletal) and history of present illness elements (location, associated signs and symptoms). The examination was limited to the affected body area. The Provider reviewed the Agreed Medical Examiner's report. The Provider requested authorization for surgery, post-operative physical therapy and CPM machine for seven days. The medical-decision making appears to be of low complexity. The code assignment of CPT 99213 by the Claims Administrator was appropriate.

The second disputed code is the Prolonged Evaluation and Management code 99354. The description of CPT 99354 is "Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour." Prolonged service with direct patient contact is reported in addition to the designated Evaluation and Management service at any level. Per the OMFS General Information and Instructions, where 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

code, then CPT 99354 may be charged in addition to the charge for the appropriate Evaluation and Management code. The report documented a total of 1 hour and 28 minutes of time spent with the worker. Based on the documentation submitted additional reimbursement for CPT 99354 is warranted.

The third disputed code is the report code 99080 Modifier 18. The description of CPT 99080 is "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form." The description of Modifier 18 is "This Modifier is used to identify a form which is not legally mandated or a report which provides information in excess of that required pursuant to Title 8 California Code of Regulations Section 9785, which is requested by a Claims Administrator or it's authorized agent." The Provider submitted a report titled Primary Treating Physician's Progress Report Surgery Request. The Provider is the Primary Treating Physician. The contents of the report are consistent with the description and requirements of a Primary Treating Progress Report (PR-2). Per review of the OMFS General Information and Instructions under the Reports section, CPT 99081 is used when billing for Primary Treating Physician's Progress Reports. The documentation submitted did not include an authorization or request from the Claims Administrator or agent for a special report. The code assignment and reimbursement of CPT 99081 by the Claims Administrator was appropriate.

Based on the documentation submitted, an additional allowance for the disputed codes CPT 99214 Modifier 57 and CPT 99080 Modifier 18 is not warranted. The requirements of CPT 99354 were met based on the documentation submitted by the Provider. Therefore, the denial of CPT 99354 by the Claims Administrator was inappropriate.

The additional reimbursement of \$154.07 for CPT 99354 is warranted based on the following calculation:

PPO Allowance CPT 99354 (1 unit) = \$154.07

Recommended Allowance \$154.07 X 1 = \$154.07

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
99213	57		1	\$89.57	\$51.24	\$51.24	\$0.00	PPO Contract
99081	18		1	\$95.57	\$10.52	\$10.52	\$0.00	PPO Contract
99354			1	\$171.19	\$154.07	\$0.00	\$154.07	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 99354 (\$154.07) for a total of \$489.07.

The Claims Administrator is required to reimburse the provider \$489.07 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]

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