

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/23/2014

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

IBR Case Number:	CB14-0000093	Date of Injury:	10/05/1994
Claim Number:	[REDACTED]	Application Received:	01/23/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/15/2013 – 05/15/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215-93, 99358-59, 99401-59, & 99081		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/28/14, 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 \$0.00, for a total of \$335.00.**

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

Supporting Analysis:

The dispute regards the denial of services performed by the Provider on 05/15/2013 for CPT Codes 99215-93, 99358-59, 99401-59, & 99081. The Claims Administrator initially denied the charges on 08/23/2013 for the following reasons:

CPT 99215-93 - "This charge was adjusted to comply with the rate and rules of the contract indicated."

CPT 99358-59, 99401-59, & 99081 - "No separate payment was made because the value of the service is included within the value of another service performed on the same day."

For discussion purposes, the CPT Codes and relative Modifiers will be defined below.

American Medical Association Current Procedural Terminology Code Book, 1997:

- **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:
 - a comprehensive history;
 - a comprehensive examination;
 - medical decision making of high complexity;
- **CPT 99358:** Prolonged Services
- **CPT 99401:** Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.
- **Modifier - 59:** Distinct Procedural Services

Title 8, California Code of Regulations Section §9785.2 **CPT 99081** code description:

"Using DWC Form PR-2 or its equivalent (see Appendix D), when (1) the employee's condition undergoes a previously unexpected significant change; (2) 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 devices; (3) the employee's condition permits return to modified or regular work, but the employee has not reached permanent and stationary status; (4) the employee's condition requires him or her to leave work or requires a change in work restrictions or modifications; (5) the employer reasonably requests additional appropriate information. (6) A progress report shall be submitted no later than 45 days from the submission of the last progress report even if no event described in paragraphs (1)-(5), above, has occurred. Progress reports are separately reimbursable even if the change in the patient's condition or treatment warranting a progress report occurs during the surgical global follow-up period."

Official Medical Fee Schedule, General Information and Ground Rules CCR§ 9789.11(a) (1) Modifier description:

Modifier - 93: Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1.

It is important to note that the Claims Administrator has subsequently reimbursed the Provider for the services in question. The Provider, however, wishes to proceed with the IBR for remuneration of the IBR application fee. A timeline has been provided as a reference.

- 08/23/2013 - Claim Denied by Claims Administrator
- 12/06/2013 - Claim Reconsidered and Denied by Claims Administrator
- 01/13/2014 - Provider Requests IBR by Maximus
- 02/26/2014 - Claims Administrator Reimbursed \$299.40
- 03/28/2014 - Provider Request Deemed Eligible for IBR
- 04/02/2014 - Letter from Provider Indicating Reimbursement Received-Proceed with IBR.

Upon review of the treatment documentation provided, the following was acknowledged:

- ✓ Physician fulfilled reporting requirements under Title 8, California Code of Regulations Section §9785 in the form of a six (6) page PR-2 report.
 - CPT 99215 elements clearly present, addressing seven (7) patient complaints resulting in a refill of two (two prescriptions) and discussion with patient about meds and treatment plan.
- ✓ Modifier – 93, clearly documented by Provider.
 - "...accompanied by... certified Spanish-English translator.
- ✓ Extended time, CPT 99358 clearly documented by Provider.
 - "I have reviewed outside and/or U.R. documents, which required 60 minutes."
- ✓ Preventative medicine, CPT 99401, is found to inclusive in CPT 99215.
- ✓ CPT 99081 Reimbursable under Title 8, California Code of Regulations Section §9785.

Based on the above findings and the aforementioned guidelines, reimbursement is recommended for CPT Codes 99215, 99358 and 99081.

The additional reimbursement of \$299.94 for Official Medical Fee Schedule code 99215, 99358 and 99081, is warranted.

