

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

7/11/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000096	Date of Injury:	3/7/2013
Claim Number:	[REDACTED]	Application Received:	1/23/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	8/5/2013 – 8/5/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99245, 99080, 99358 and 99354		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/19/2014, 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 \$34.52, for a total of \$369.52.**

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 (OMFS) or negotiated contract: PPO Contract
- Other: OMFS General Information and Instructions

Supporting Analysis:

The dispute regards the payment amount for an office consultation (99245), report (99080) and prolonged evaluation and management services (99354 and 99358). The Claims Administrator based its reimbursement of billed code 99245 on 99215 indicating "Based on the submitted report, the service provided does not appear to be consultative in nature. The patient was already being treated by this provider/group for this injury." The Claims Administrator based its reimbursement of the billed code 99080 on 99081 indicating "99080 17 changed to 99081. Patient has been discharged from care. P&S factors are not met. Please refer to page 5-6 of the OMFS." The Claims Administrator denied reimbursement of billed code 99358 indicating "Per OMFS pg. 17 states: Prolonged service of less than 15 min. Beyond the first 15 min is not reported separately. "0-29 min w/EM service is not separately payable and is included in the EM. 30 min + must be spent of a payable service for 99358 w/EM."

Per the Independent Bill Review application, the reason for Provider's dispute was stated as "99245 and 99080 reduced to 99215 and 99081, respectively. Carrier reduces 99358 improperly. Carrier fails to properly adjust 99354 concomitant with reduction of 99245."

- **CPT 99245:** Office consultation for a new or established patient, which requires these three key components: Comprehensive history; Comprehensive examination; and Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
- **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.

Based on a review of the report submitted by the Provider, the worker was initially evaluated on March 18th, 2013, diagnosed by the Provider and per the Provider "intended to provide individual outpatient psychotherapy, augmented with psychoactive medication.

The Claims Administrator submitted a letter to MAXIMUS further explaining the decision to reimburse CPT 99245 as 99215, explanation was "Code 99245 was recommended as 99215 due to the patient being seen as a consultation on 3/18/2013 by the same MD/group. The physician/group has been treating the patient on an ongoing basis since."

- **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: Comprehensive history; Comprehensive examination; and Medical decision making of high complexity.

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. Per a review of the medical record, OMFS Guidelines and submitted documentation, the evaluation and management

services appear to be a follow-up from the initial evaluation on 3/18/2013 and would not be considered an Office Consultation. If consultant assumes responsibility for management of a portion or the entire patient's condition(s) follow-up consultation codes should not be used. In the office setting, the appropriate established patient codes should be used. The code assignment and reimbursement of CPT 99215 by the Claims Administrator was correct.

The Provider submitted a report titled "Permanent and Stationary Psychiatric Consultation Report of Primary Treating Physician." The Provider is disputing the code assignment and reimbursement of CPT 99081 for billed code 99080. Per the Claims Administrator's dispute, "Report 99080 was changed to 99081 due to the injured worker (IW) not meeting the P&S definition. There is 0% impairment, the IW can return to work without limitations and there is no need for future medical care."

Per the submitted report, "patient was temporarily totally disabled from 3/3/2013 – 3/23/2013, injured worker (IW) can be considered MMI from a psychiatric standpoint with GAF of 78 creating a WPI of 0%. Causation of injury: Admitted and Apportionment: Not at issue in absence of permanent impairment." Recommendations were documented as: There is no need for future psychiatric treatment; and there is no psychiatric impairment to preclude continuation of the patient's usual work. No psychiatric work restrictions.

The submitted report appears to a Primary Treating Physician's Final Discharge Report, which would be billed and reimbursed as CPT 99081. Per the OMFS General Information and Instructions, a Primary Treating Physician's Final Discharge Report is separately reimbursable as 99081 when the physician determines that no further medical treatment is needed for this injury, the patient has no permanent disability, and the employee is able to return to work with no restrictions or diminished capacity related to this injury. The reimbursement of CPT 99081 by the Claims Administrator was correct.

The third disputed code is the prolonged services code 99358. The Provider billed two units of 99358 and reported 25 minutes of record review. Per the OMFS General Information and Instructions, code 99358 is used to report each fifteen minutes of prolonged service on a given date regardless of the place of service with the exceptions: prolonged service of less than 15 minutes total duration on a given date is not separately reported and prolonged service of less than 15 minutes beyond the first 15 minutes is not reported separately. Reimbursement is warranted for one unit of the billed code 99358, due to the Provider documented 25 minutes of record review and prolonged service of less than 15 minutes beyond the first 15 minutes is not reported separately.

The Provider billed procedure code 99354 prolonged direct face-to-face services with the injured work. The Provider submitted charges of \$180.20 for the billed procedure code 99354 x 1. Per the PPO contract, Workers' Compensation services Provider shall be reimbursed the lesser of the following: 80% of billed charges; 95% of usual and customary and reasonable prevailing rates; or 95% of the current applicable federal or state mandated fee schedule or federal or state mandated DRG. The Provider was reimbursed \$144.16; reimbursement was based on 80% of billed charges which was less than 95% of the OMFS allowance of \$171.19. The reimbursement by the Claims Administrator was correct per the submitted PPO contract.

The additional reimbursement of \$34.52 is warranted per the Official Medical Fee Schedule code 99358. There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 99215, 99081 and 99354.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99215	1	\$123.56	\$122.94	\$122.94	\$0.00	PPO Contract
99081	1	\$299.47	\$11.11	\$11.11	\$0.00	PPO Contract
99358	1	\$76.58	\$34.52	\$0.00	\$34.52	PPO Contract
99354	1	\$0.00	\$144.16	\$144.16	\$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 code 99358 (\$34.52) for a total of \$369.52.

The Claims Administrator is required to reimburse the provider \$369.52 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

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