

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 30, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000507	Date of Injury:	08/02/2013
Claim Number:	[Redacted]	Application Received:	03/28/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99245, 99080, 99358, 96100 and 96115		

Dear [Redacted]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

IBR Case Assigned: 06/06/2014

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$335.00 for the review cost and \$590.42 in additional reimbursement for a total of \$925.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$925.42 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[Redacted]
[Redacted]

cc: [Redacted]
[Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- National Correct Coding Initiatives
- Other: OMFS General Information and Instructions; CPT Assistant

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE:** Provider dissatisfied with reimbursement of codes 99245, 99080, 99358, 96100 & 96115
- Provider was reimbursed \$372.38 for a Psychological Evaluation authorized by Claims Administrator (authorization included in documentation received) and is seeking additional reimbursement of \$1762.62.
- Claims Administrator down coded CPT 99245 to 99243 indicating on the Explanation of Review: “After review of the bill and the medical record, this service is best described by code 99243. Submitted documentation did not meet the key components required for 99245.”
- 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.
- The worker was referred to the Provider for a Psychological Evaluation. The medical record submitted documents a detailed history which included: chief complaint and history of present illness. The worker had sustained a psychological stress injury while performing his usual and customary duties. This stress injury resulted from being a victim of armed robbery. The presenting problem is considered moderate severity as the risk of morbidity without treatment is moderate; uncertain prognosis or increased probability of prolonged functional impairment. The medical documentation demonstrated a comprehensive examination and medical decision making. The medical record did not demonstrate all of the required elements of CPT 99245. Therefore, the Claims Administrator’s code assignment and reimbursement of the consultation code 99243 was correct. The description of the CPT 99243 is “Office consultation for a new or established patient, which requires these three key components: detailed history; detailed examination; and Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate to high severity.” Additional reimbursement is warranted.

- The second disputed service is the report code 99080. The Provider billed and was reimbursed for an office consultation code 99243. Per the Official Medical Fee Schedule General Information and Instructions, a report by a consulting physician is separately reimbursable using CPT 99080 where a consultation was requested on one or more medical issues by the treating physician, including second opinion on the medical necessity or appropriateness of a previously recommended medical treatment or surgical procedure. Based on the documentation submitted, the billed procedure code 99080 meets the OMFS definition and description of a separately reimbursable report due to: the consultation was requested by a treating physician for a psychiatric consultation for one or more medical issues. The Provider submitted a 16 page report and billed procedure code 99080 and was reimbursed as “The amount paid reflects a fee schedule reduction.” Based on the OMFS General Information and Instructions, the maximum number of pages reimbursed for procedure code 99080 is six. Additional reimbursement is warranted for CPT 99080.
- Provider billed and was reimbursed for CPT code 99358. CPT 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 inpatient or outpatient setting. The Provider must document the types of patient care and length of time spent. Provider did not document time spent reviewing records or tests, job analysis, evaluation of ergonomic status, work limitations, or work capacity (not face-to-face). Therefore, no additional reimbursement is warranted.
- Billed CPT code 96100 was denied completely as “CPT code 96100 was denied as “Medical documentation provided does not support the service (or level of service) billed. “ CPT code 96100 is described as “Psychological testing (includes psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour.” Provider did resubmit the claim with documentation showing time spent on the CMS 1500 form totaling 5.5 hours. Super Bill submitted documents each type of test performed per 96100. Additional reimbursement is warranted.
- CPT code 96115 was billed and reimbursed as “The charge for this procedure exceeds the fee schedule allowance.” CPT code 96115 is described as “Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language functions, planning) with interpretation and report, per hour.” Reporting Guidelines for Time-Based Codes pursuant CPT Assistant October 2011, Volume 21, Issue 10, pages 3-4, 11, “Time units are reported once the midpoint is reached. The time guidelines clearly define that a unit of time is attained when the midpoint of the time indicated has been passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes).” Provider documents time in her report as 15 minutes for procedure 96115. Therefore, no additional reimbursement is warranted for CPT 96115.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, additional reimbursement is warranted for CPT codes 99243, 99080 and 96100.

The table below describes the pertinent claim line information.

Date of Service: 11/26/2013						
[REDACTED]						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99243	\$ 315.00	\$ 111.88	\$ 203.12	1	\$ 131.62	Additional Reimbursement \$19.74
99080	\$220.00	\$131.61	\$88.39	13 Pages	\$152.78	Additional Reimbursement \$21.17
99358	\$100.00	\$61.78	\$38.22	Na	\$0.00	No Additional Reimbursement
96100	\$1350.00	\$0.00	\$1350.00	5.5 Hours	\$549.51	Allow Additional \$549.51
96115	\$150.00	\$67.11	\$82.89	15 Minutes	\$0.00	No Additional Reimbursement

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]