



## **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
- PPO Contract

## **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 seeking \$138.03 in additional remuneration for 92690 Cardioversion, elective, electrical conversion of arrhythmia; external and 93005 Electrocardiogram Tracing performed on 04/09/2014.**
- The Claims Administrator reimbursed the Provider for service in accordance with the 2014 OMFS.
- OMFS Fee Schedule on or before September 1, 2104 will be utilized.
- **OMFS § 9789.32 (c)** The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined as follows: (1) The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 92690 & 93005.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 92690 & 93005**

<b>Date of Service:</b> 04/09/2014						
Hospital Outpatient						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
92690	\$5,468.68	\$137.90	\$113.02	1	\$250.92	<b>\$113.02 Due Provider</b>
93005	\$816.29	\$10.05	\$25.01	1	\$35.06	<b>\$25.01 Due Provider</b>

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