

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Upheld

4/24/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator Name: [REDACTED]
Date of Disputed Services: 1/22/2013 – 1/22/2013
MAXIMUS IBR Case: CB13-0000160

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/24/2013, 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 upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

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
- Other: OMFS General Information and Instructions, Code descriptions and guidelines

Supporting Analysis:

The dispute regards the denial of duplex scan (93880), pharmacologic management (90862), report services (99080) and the payment amount of prolonged services (99358) and handling services (99000). The Claims Administrator denied the billed procedure code 93880 with the explanation "Billed charges not related to a WC injury." The Claims Administrator denied the billed procedure code 90862 with the explanation "By clinical practice standards, this procedure is incidental to the related primary procedure billed." The Claims Administrator denied the billed procedure code 99080 with the explanation "The report is included in another procedure on this date of service." The Claims Administrator reimbursed \$32.71 for the billed procedure 99358 and \$5.79 for the billed procedure code 99000.

CPT 93880 - Duplex scan of extracranial arteries; complete bilateral study

CPT 90862 – Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

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 fifteen minutes

CPT 99000 – Handling and/or conveyance of specimen for the transfer from the physician's office to a laboratory

The first disputed service is the duplex scan procedure code 93880. The Claims Administrator denied the service as not related to the Workers' Compensation Injury. The worker's injury and the medical necessity of the test and as it relates to the injury could not be determined based on the documentation submitted with the Independent Bill Review case. The documentation submitted with the case included: claim form documenting billed codes, dates of service and diagnoses (V72.83 and 535.50); initial explanation of review (EOR) and EOR in response to the second bill review request; Provider's request for second bill review; Initial Comprehensive Preoperative Consultation; and diagnostic test results.

The second disputed service is the pharmacologic management code 90862. The CPT code 90862 refers to the in-depth management of psychopharmacologic agents that are potent medications with frequent serious side effects, and represents a very skilled aspect of patient care. The medical record did not document an in-depth management of psychopharmacologic agents. The current medications were documented in the record. The medical record documented medication management services typically included in or part of the Evaluation and Management services billed as CPT 99245. The documentation submitted did not support the reimbursement of CPT 90862.

The third disputed service is the report code 99080. The Provider submitted a report titled "Initial Comprehensive Preoperative Consultation." The type of report submitted by the Provider was not a Primary Treating Physician Progress Report (PR-2), or a separately reimbursable report as described in the OMFS General Information and Instructions Separately Reimbursable Treatment Reports section, therefore, the denial of the report code 99080 by the Claims Administrator was correct.

The fourth disputed code is the prolonged services code 99358. Per review of the OMFS Evaluation and Management section, code 99358 is used when a physician provides prolonged service not involving direct care that is beyond the usual service in either the inpatient or outpatient setting. The CPT code 99358 may be used when the physician is required to spend 15 or more minutes before

and/or after direct (face-to-face) patient contact in reviewing extensive records, tests or in communication with other professionals. The Provider did not document the amount of time spent on record review or any other type of activity described under procedure code 99358. The Provider billed the procedure code 99358 with one unit. Based on a review of the explanation of review (EOR), the Claims Administrator reimbursed the Provider for one unit of procedure code 99358. The allowance was based on the Official Medical Fee Schedule minus a PPO discount. No additional reimbursement is recommended for the billed procedure code 99358.

The fifth disputed service is the procedure code 99000. The Claims Administrator reimbursed the Provider the OMFS allowance for the billed procedure code 99000 minus the PPO contract. No additional reimbursement is recommended for the billed procedure code 99000.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 93880, 99358, 90862, 99080 and 99000.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
93880	1	\$225.71	\$0.00	\$0.00	\$0.00	PPO Contract
99358	1	\$43.79	\$32.71	\$32.71	\$0.00	PPO Contract
90862	1	\$50.43	\$0.00	\$0.00	\$0.00	PPO Contract
99080	1	\$162.98	\$0.00	\$0.00	\$0.00	PPO Contract
99000	1	\$0.98	\$5.79	\$5.79	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS codes and description, medical record and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$38.50 is upheld.

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

Copy to:

██████████
 ██████████
 ██████████

Copy to:

[REDACTED]