

MAXIMUS FEDERAL SERVICES, INC.

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

7/25/2013

Independent Bill Review Final Determination Upheld

[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 1/2/2013 – 1/2/2013
MAXIMUS IBR Case: CB13-0000046

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 5/29/2013, 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 Information and Instructions Effective 1/01/2004, Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Chapter III, B and Corvel PPO contract

Supporting Analysis:

The dispute regards the denial of CPT 99212 Modifier 25, CPT 99086 and HCPCS A4550 for date of service 1/2/2013. The Claims Administrator denied payment for CPT 99212 Modifier 25 indicating "The submitted documentation does not identify significant, separately identifiable services greater than those usually required for the listed procedure." The HCPCS A4550 was denied by the Claims Administrator indicating "No allowance is recommended for this supply/material as it is necessary to perform the services rendered and is considered embedded in the value of that service." The last disputed CPT 99086 was denied by the Claims Administrator stating "Chart notes/duplicate reports were not requested."

A review of the record indicates the provider submitted the following billed charges for services on clinical date of service 1/2/2013:

CPT 99212 Modifier 25	Provider Billed \$75.00
CPT 11100 Modifier 59	Provider Billed \$150.00
CPT 11101 Modifier 59	Provider Billed \$150.00
HCPCS A4550	Provider Billed \$50.00
CPT 99080	Provider Billed \$60.00
CPT 99086	Provider Billed \$90.00
CPT 17004	Provider Billed \$450.00

The provider billed for CPT Evaluation and Management code 99212 Modifier 25 on the same day as minor surgical procedure. Per the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 3, Section B, Evaluation and Management Services, "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure." The surgical procedure codes billed by the Provider all have global periods of either 000 or 010 days. The Centers for Medicare Medicaid Services (CMS) National Correct Coding Initiative guidelines state that "E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure." The exception to this guideline is if a provider performs a significant and separately identifiable E&M service unrelated to the decision to perform the surgical procedure and a Modifier 25 is appended to the E&M service. A significant and separately identifiable E&M service was not identified in the documentation submitted. Therefore, reimbursement for the CPT 99212 Modifier 25 is not warranted.

The second disputed code is the Miscellaneous Supply code HCPCS A4550. The description of A4550 is "surgical trays." The OMFS instructions state that supplies and/or materials normally necessary to perform the service are not separately reimbursable. According to the OMFS General Information and Instructions the exception to the rule is "sterile trays for laceration repair and more complex surgery." The billed surgical procedures were not considered complex or a laceration repair. The documentation does not support separate reimbursement for HCPCS A4550.

The third disputed billed procedure is CPT 99086 "Chart Notes." Based on the OMFS General Information and Instructions, request for chart notes shall be in writing and be made only by the Claims Administrator. A request for chart notes from the Claims Administrator was not submitted as part of the documentation. Reimbursement for CPT 99086 is not warranted.

Based upon the documentation submitted an additional allowance for the disputed codes is not warranted. The decision by the Claims Administrator was appropriate.

There is no additional reimbursement warranted per the PPO Contract code CPT 99212 Modifier 25, HCPCS A4550 and CPT 99086.

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

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
99212	25		1	\$75.00	\$0.00	\$0.00	\$0.00	PPO Contract
A4550			1	\$50.00	\$0.00	\$0.00	\$0.00	PPO Contract
99086			3	\$90.00	\$0.00	\$0.00	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS General Information and Instructions, Medicare National Correct Coding Initiative guidelines and comparison with PPO Contract. This was determined correctly by the Claims Administrator and the payment of \$0.00 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:

Division of Workers' Compensation Medical Unit
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