

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 23, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000330	Date of Injury:	06/12/2009
Claim Number:	[REDACTED]	Application Received:	02/26/2016
Assignment Date:	03/16/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/02/2015 – 04/02/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	93892 and 93886		

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.

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 \$195.00 for the review cost and \$229.66 in additional reimbursement for a total of \$424.66. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$424.66** 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,

Paul Manchester, M.D., M.P.H.
Medical Director

[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
- OMFS

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 \$229.66 in remuneration for 93892 and 93886 performed on 04/02/2015.**
- The Claims Administrator's reimbursement rational indicates "scheduled allowance."
- EOR's and UB-04, Bill Type 131, do not reflect services other than radiology.
- Opportunity to Dispute Eligibility communicated to Claims Administrator 02/29/2016; response not yet received.
- Contractual Agreement not submitted for review; OMFS will be utilized.
- **Relevant Code Description:**
 - 93886 Intracranial Complete Study
 - 93892 Tcd Emboli Detect W/o Inj., Primary Procedure
- **CCR 9789.32 (c)(B) (i)** If the Other Service has a Professional Component/**Technical Component under the OMFS RBRVS**, the hospital outpatient facility fee shall be the **Technical Component amount determined according to the OMFS RBRVS.**
- **§ 9789.15.6 Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction**
 - (a) The Multiple Procedure Payment Reduction (MPPR) on diagnostic cardiovascular procedures applies when multiple services are furnished to the same patient on the same day. The MPPR applies to Technical Component (TC)-only services, and to the TC of global services. Full payment is made for the TC service with the highest payment. Payment is made at **75 percent for subsequent TC** services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. The MPPR does not apply to professional component (PC) services. See section 9789.19 for the location of the list of codes subject to the MPPR on diagnostic cardiovascular procedures, by date of service.
- The TC Medicare MPPR is 50% **Labor Code section 5307.1, subdivision (a)(2)(B):** "The **Official Medical Fee Schedule shall include payment ground rules that differ from Medicare payment ground rules**, including, as appropriate, payment of consultation codes and payment evaluation and management services provided during a global period of surgery."
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 93832 and 93886.**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 93892 and 93886

Date of Service: 04/02/2015 HOPPS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
93892	\$2,063.70	\$156.41	\$211.33	1	\$367.74	Refer to Analysis \$211.33 Due Provider
93886	\$1,508.17	\$220.24	\$18.33	1	\$238.57	Refer to Analysis \$18.33 Due Provider

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]