INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 20, 2015

Dear [Name],

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 $250.00 for the review cost and $950.31 in additional reimbursement for a total of $1,200.31. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1,200.31 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,

cc: [Contact Information]
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

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 full remuneration for 14040 Tissue Transfer, 26765-51 Open Treatment of Distal Phalangeal Fracture, 11760 -51 Repair of Nail Bed, performed on 12/19/2013.
- EOR 06/26/2014 and 09/30/2014 submitted for review of 12/19/2013 date of service.
- Claims Administrator denied service indicating the following: “This item has been reviewed on a previously submitted bill, or is currently in process.”
- Reimbursement on submitted EORs is $0.00.
- Treatment report indicates Injured Worker sustained a “partial amputation left thumb,” and was referred to Provider for treatment post referral from an outpatient clinic due to the “extent” of the Injured Worker’s injury.
- Documentation entitled “Emergency Authorization for Treatment” signed by the Injured Worker’s “HR Director” on 12/19/2013 authorized the following: “The patient requires immediate surgery as determined by (Dr. Ali Heidari), and it must be performed urgently at (Contour Aesthetic Surgery Center)”
- Documentation acknowledges the urgent medical services in question were performed on an Injured Worker do to an industrial related accident while utilizing a “hand grinder” at work.
- Documentation acknowledges authorization was provided by Injured Worker’s Human Resources Director for the urgent medical services relating to the industrial related injury.
The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes 14040, 26765-51 and 11760-51 is warranted.

<table>
<thead>
<tr>
<th>Date of Service: 12/19/2013</th>
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<tr>
<td><strong>Physician Services</strong></td>
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<tr>
<td><strong>Service Code</strong></td>
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<td>14040</td>
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<td>26765-51</td>
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<td>11760-51</td>
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Copy to:

[redacted]

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