

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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: OMFS Physician 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 is dissatisfied with denial of codes 64702 and 35761.
- Claims Administrator denied codes and indicated on the Explanation of Review “These services were submitted on the incorrect billing form. Please resubmit the bill on the correct form.”
- Provider billed codes 64702 (Neuroplasty; digital, 1 or both, same digit) and 35761 (Exploration (not followed by surgical repair), with or without lysis of artery; other vessels) on a CMS 1500 for Physician Services.
- Based on review of the operative report, provider performed a dissection of the right index finger and removal of foreign body.
- Documentation reviewed included Case Summary Report from Utilization Review approving “Exploration right index finger with removal foreign body 20525, 20103”
- Based on information reviewed, Claims Administrator was incorrect to deny claim. Therefore, reimbursement of codes 64702 and 35761 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 64702 and 35761-51 is warranted.

Date of Service: 4/22/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64702	\$837.24	\$0.00	\$837.24	N/A	100%	\$837.24	DISPUTED SERVICE: Allow reimbursement \$837.24
35761-51	\$349.43	\$0.00	\$349.43	N/A	50%	\$329.43	DISPUTED SERVICE: Allow reimbursement \$329.43

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