

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001076	Date of Injury:	03/04/2014
Claim Number:	[Redacted]	Application Received:	08/01/2014
Claims Administrator:	[Redacted]	Assignment Date:	09/24/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	26567 and 15004-51		

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 \$ for the review cost and \$676.10 in additional reimbursement for a total of \$926.10.A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$926.10 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,

[Redacted]
[Redacted]

cc: [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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule, Title 8, California Code of Regulations, Article 5.3 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 is dissatisfied with reimbursement of codes 26567 and 15004-51.
- Claims Administrator reimbursed \$1891.28 and indicated on the Explanation of Review for code 26567 “The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.” For code 15004-51, Explanation of Review states “Reimbursement for this is included with other services provided on the same day. Therefore a separate payment is not warranted.”
- Provider billed CPT codes 26567, 15240, 14040, 15004 and 11760. Provider states CPT 26567 was the main procedure on date of service 03/04/2014. However, Claims Administrator reduced CPT 26567 by 50% per multiple surgery Rule #7 but did not pay the highest valued code at 100%, or any of the codes at 100%.
- Pursuant to Title 8, California Code of Regulations, Article 5.3 Official Medical Fee Schedule, §9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for physician and Non-Physician Practitioner Services –For Services Rendered On or After January 1, 2014 (a) Maximum reasonable fees for physician and non -physician

practitioner medical treatment provided pursuant to Labor Code section 4600, which is rendered on or after January 1, 2014, shall be no more than the amount determined by the Official Medical Fee Schedule for Physician and Non – Physician Practitioners, consisting of the regulations set forth in Sections 9789.12.1 through 9789.19 (“Physician Fee Schedule.”) Maximum fees for services rendered prior to January 1, 2014 shall be determined in accordance with the fee schedule in effect at the time the service was rendered. The Physician Fee Schedule shall not govern fees for services covered by a contract setting such fees as permitted by Labor Code section 5307.11.

- §9789.16.5 Surgery – Multiple Surgeries and Endoscopies (a) General Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co - surgeons, surgical teams, or assistants – at - surgery may participate in performing multiple surgeries on the same patient on the same day.
- The Multiple Procedure (“Multi Proc.”) column of the National Physician Fee Schedule Relative Value File contains a “2” to indicate procedures that are subject to the surgery multiple procedure payment reduction. If a procedure is performed on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure reduced by the applicable percentage. Rank the procedures subject to the multiple surgery rules (indicator “2”) in descending order by fee schedule amount and apply the appropriate reduction to this code: (A) 100 percent of the fee schedule amount for the highest valued procedure; and (B) 50 percent of the fee schedule amount for the second through the fifth highest valued procedures.
- Claims Administrator was correct to reimburse CPT 26567 according to the multiple surgery rule as it does not contain the highest value of the procedures performed on date of service 03/04/2014. And therefore, no additional reimbursement is warranted for CPT 26567.
- Claims Administrator should have reimbursed CPT 15240 as the primary procedure as it has the highest value. However, the Claims Administrator failed to reimburse CPT 15240 according to the Official Medical Fee Schedule of 100%. Therefore, additional reimbursement for CPT 15240 is warranted and shall be reimbursed according to the Official Medical Fee Schedule.
- CPT 15004 - Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq. cm or 1% of body area of infants and children.
- Based on review of Provider’s Operative Report submitted, documentation does not support the use of code 15004. Therefore, reimbursement of CPT 15004 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code 15240 is recommended.

Date of Service: 3/4/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
26567	\$1075.00	\$569.33	\$505.67	N/A	50%	\$569.33	DISPUTED SERVICE: No reimbursement recommended.
15240	\$676.00	\$676.00	\$0.00	N/A	Main Procedure 100%	\$1352.10	DISPUTED SERVICE: Allow reimbursement \$676.10
15004-51	\$226.52	\$0.00	\$226.52	N/A	50%	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

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