

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 29, 2014

██████████
██████████
██████████

IBR Case Number:	CB14-0001145	Date of Injury:	08/15/2012
Claim Number:	██████████	Application Received:	08/15/2014
Claims Administrator:	██████████	Assignment Date:	09/24/2014
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	26145 x9 Units, 64721		

Dear ██████████

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 \$3,558.38 in additional reimbursement for a total of \$3,808.38. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3,808.38 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,

██
Medical Director

cc: ██████████
██

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 26145 x 9 Units and 64721 surgical services performed on 04/23/2014.**
- Claims Administrator reimbursed 26145 synovectomy, tendon sheath, radical (tenosynovectomy), flexor tendon, palm and/or finger, each tendon as 25115 Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors with the following rationale: “the procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.”
- EOR 06/02/2014 and 07/16/2014 do not indicate 26145 and 64721 services as unauthorized.
- Operative report reflects Provider began incision “**in the palm** extending from Kaplan’s line distally to the edge of the glabellar skin proximally and in line with the fourth ray.”
- Claims Administrator code assignment, 25115 represent “synovectomies at **wrist**.” Operative report does not reflect surgical procedure(s) performed at anatomical site specified by 25115 as Provider surgical procedures remained in the area of the right palm.
- Reimbursement is warranted for 26145, as the Primary Procedure; MPPR 2014 cascade applies.

- Claims Administrator denied reimbursement for 64721 stating, “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- CPT 64721 is inclusive to the Claims Administrator code re-assignment 25115 but it is not inclusive to original CPT 26145.
- Reimbursement is warranted for 64721; MPPR 2014 cascade applies.
- Contractual agreement not provider for IBR, OMFS will be utilized.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 26145 x 9 Units and 64721.

Date of Service: 06/16/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
26145	\$13,032.00	\$1,077.00	\$11,955.00	N/A	1	\$4,274.39	\$854 2014 MPPR 100,50%,50%... – Reimbursed Amount = \$3,197.39 Due Provider
64721	\$1,738.00	\$0.00	\$1,738.00	N/A	1	\$361.00	MPPR 50% Refer to Analysis

Copy to:

██████████
 ████████████████████
 ████████████████████████████████

Copy to:

██
 ██
 ██