

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 02, 2015

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001489	<b>Date of Injury:</b>	07/18/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/06/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	11/07/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	26756-59-F7, 13131-51-F7 and 26750-59-51		

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 \$250.00 for the review cost and \$220.32 in additional reimbursement for a total of \$470.32. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$470.32 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]  
Medical Director

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: PPO Contract Discount 10%
- National Correct Coding Initiatives

## 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 26756-59 and 26750-59 and denial of code 13131-F7.
- Based on the NCCI edits, generally these codes are not reported together. However, Modifier Indicator column shows '1' which means that if an appropriate modifier is appended to the correct CPT code and documentation is submitted to support the use of the modifier, then the edit may be overridden.
- Based on review of the operative report, provider does document the procedure codes performed crush injury to right middle finger and left middle finger surgery.
- Claims Administrator reimbursed codes 26756-59 and 26750-59 in the amount of \$120.50 indicating on the explanation of review "This charge was adjusted to comply with the rate and rules of the contract indicated."
- Provider billed codes 26756, 26750 and 13131. Pursuant Surgery Rule #7, multiple surgical procedures performed at the same session is calculated as follows: Major (highest valued) procedure: 100% of listed value; Second highest valued or equivalent procedure: 50% of listed value; third highest valued procedure: 25% of listed value.
- Claims Administrator reimbursed code 26756 as the second highest valued procedure and 26750 as the third highest, which was correct. Code 13131 was the highest valued procedure but Claims Administrator denied this code.

- Based on information reviewed, reimbursement of code 13131 is warranted.
- PPO contract was received and a 10% discount is to be applied.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 13131 is recommended.**

Date of Service: 7/19/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
13131	\$209.10	\$0.00	\$209.10	1	100%	\$220.32	<b>DISPUTED SERVICE:</b> Allow reimbursement \$220.32 per OMFS 2013
26756	\$	\$103.28	\$704.33	1	50%	\$103.28	<b>DISPUTED SERVICE:</b> No reimbursement recommended
26750	\$	\$17.22	\$215.90	1	25%	\$17.22	<b>DISPUTED SERVICE:</b> No reimbursement recommended

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 19.2 7/1/2013-9/30/2013	26750	13131	Allow Modifier
Physician Version Number: 19.2 7/1/2013-9/30/2013	26756	13131	Allow Modifier
Physician Version Number: 19.2 7/1/2013-9/30/2013	26756	26750	Allow Modifier

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