

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 4, 2015

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001819	<b>Date of Injury:</b>	02/02/2014
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	11/24/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	12/31/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	14040, 14040-51, 26440-51, & 26440-51		

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 \$846.30 in additional reimbursement for a total of \$1,096.30. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1,096.30 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,

Paul Manchester, M.D., M.P.H.  
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
- American Medical Association CPT 2014
- Partial Contractual Agreement: 95% OMFS

## 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 questioning reimbursement cascade for 14040, 14040-51, 26440-51, & 26440-51 surgical services performed on 08/14/2014.**
- Claims Administrator reimbursed \$162.00 of \$625.00 with the following rationale: “The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.”
- **Modifier 51: Multiple Procedure**
- **CPT 14040 Code Description:** Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less.
  - **Relative Weight 18.8682**
- **CPT 26440 Code Description:** Tenolysis, flexor tendon; palm OR finger, each tendon
  - **Relative Weight 17.2090**
- Title 8, Article 5.3, Services on or after January 1, 2004, Prior to September 1, 2014, Section 9789.38. Appendix X. 42 C.F.R. § 419.44 (a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on – (1) The full amounts for the procedure with the highest APC payment rate; and (2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

The table below describes the pertinent claim line information and payment pursuant to C.C.R. §9789.33, Outpatient Facility Fee Schedule = APC relative weight x adjusted conversion factor x .82, Workers' Compensation multiplier pursuant to Section 9789.30(x) & 95% PPO Contractual Amount.

**DETERMINATION OF ISSUE IN DISPUTE: 14040, 14040-51, 26440-51, & 26440-51**

Date of Service 08/14/2014							
Ambulatory Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
14040	\$1,244.7	\$488.45	\$694.04	N/A	1	\$1,182.48	PPO Contract \$694.03 Due Provider
14040-51	\$622.36	\$488.45	\$102.80	N/A	1	\$591.24	PPO Contract \$133.91 Due Provider
26440	\$567.63	\$539.25	\$28.38			\$539.25	\$0.00 Due Provider
26440	\$567.63	\$520.89	\$46.74			\$539.25	PPO Contract \$18.36 Due Provider

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