



## 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 remuneration for Physician Surgical services 25295 - 51-59 Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon, Status Indicator "T," 26442 -51-59 Tenolysis, flexor tendon; palm and finger, each tendon Status Indicator "T," & 26442-51-59 for date of service 05/15/2014.**
- The Claims Administrator denied services based on the following rationale: "No separate payment was made because the value of the service is included in the value of another service performed on the same day."
- **CPT 25295** reflects MUE of "9." EOR indicates x 5 25295 procedures billed; 4 of 5 reimbursed. Operative Report and MUE support use of 25295 -51-59.
- Documentation reflects operative procedures, right upper extremity involving wrist, palm and PIP joints. Procedures 26442 and 26442 with supportive modifiers correctly appended to procedures.
- CMS 1500 and EOR's reflect Primary Procedure Code as 26525.
- Based on the aforementioned documentation and guidelines, 2013 MPPR 100/50/25 reimbursement is warranted for 25295 -51-59, 26442 -51-59, and 26442-51-59.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 25295 -51-59, 26442 -51-59, 26442-51-59**

<b>Date of Service: 05/05/2014</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
26442	\$299.00	\$0.00	\$299.00	N/A	1	\$298.35	Refer to Analysis
26442	\$150.00	\$0.00	\$150.00	N/A	1	\$149.18	Refer to Analysis
25295	\$110.00	\$0.00	\$111.00	N/A	1	\$110.93	Refer to Analysis

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