

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 3, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001838	Date of Injury:	08/06/2014
Claim Number:	[REDACTED]	Application Received:	12/01/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/2/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	26418, 26418-51, 29125-51		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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, MD, MPH
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:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 26418, 26418-51 and 29125
- Claims administrator denied code 26418-51 indicating “Service unsubstantiated by documentation” and denied code 29125 indicating “Included in another billed procedure.”
- CPT 26418 - Repair, extensor tendon, finger, primary or secondary; without free graft, **each tendon**
- Based on review of the operative report, provider documents “The central slip and ulnar lateral band of the extensor are lacerated and are repaired with interrupted 4-0 Tycrom figure of 8 sutures”. The central slip and ulnar lateral band are not separate tendons. The extensor tendon is the only tendon documented and therefore 26418 should not have been billed twice. Additional reimbursement of 26418-51 is not warranted.
- CPT 29125 - APPLY FOREARM SPLINT, and has an ASC Payment Indicator of P3-Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs. This service is packaged and therefore no reimbursement is warranted for 29125.

- Claims administrator reimbursed \$986.94 for code 26418 indicating on the Explanation of Review “The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.”
- Pursuant **Section 9789.33. Determination of Maximum Reasonable Fee**, for services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers’ compensation multiplier for hospital outpatient departments and 0.82 workers’ compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).
- PPO contract shows a discount of 10% is to be applied to reimbursement. According to the HOPPS reimbursement figure above, no further reimbursement is warranted for code 26418.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 26418, 26418-51 and 29125 is not recommended.

Date of Service: 8/8/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
26418	\$2599.53	\$986.94	\$1502.93	100%	\$943.57	DISPUTED SERVICE: No further reimbursement recommended.
26418-51	\$1169.16	\$0.00	\$1169.16	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
29125	\$90.96	\$0.00	\$90.96	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

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