

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 18, 2015

██████████
██████████
██████████

IBR Case Number:	CB14-0001909	Date of Injury:	06/29/2014
Claim Number:	██████████	Application Received:	12/10/2014
Claims Administrator:	██████████		
Assigned Date:	1/20/2015		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	99203-59, 14040		

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 \$202.80 in additional reimbursement for a total of \$452.80. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$452.80 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, MD, MPH
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
- Negotiated contracted rates: PPO 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 denial of code 99203-57 and reduced payment of 14040 for date of service July 1, 2014
- Claims administrator denied code 99203-57 indicating on the Explanation of Review “The visit or service billed occurred within the global surgical period and is not separately reimbursable”
- Provider’s report submitted documents that the patient had sustained a work related injury three days prior to this evaluation: “The patient sustained a crush injury by a lettuce bin on June 29, 2014 to his left index finger.” The provider’s report documents a Chief complaint, History of Injury, Past Medical History, Physical Exam, medical decision to have x-rays taken at this appointment which then led to the provider’s assessment for a surgical procedure needed to the patient’s left index finger.
- Provider billed 99203 with a modifier -57: Decision for surgery
- Pursuant CMS NCCI Policy 1/1/2014, if a procedure has a global period of 90 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

- OMFS shows CPT 14040 with a Global Period of 90 days. Therefore, reimbursement of 99203-57 is warranted.
- Provider also billed code 14040 which claims administrator reimbursed \$834.30. The OMFS shows reimbursement of 14040 as \$1065.68. PPO contract shows a 10% discount is to be applied to reimbursement which would equal \$959.11 as it was the primary procedure and is reimbursed at 100%. Additional reimbursement is warranted for CPT 14040.
- Maximus does not review for calculation of interest and penalties.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99203-57 and 14040 is recommended

Date of Service: 7/1/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99203-57	\$125.39	\$0.00	\$125.39	1	N/A	\$77.99	DISPUTED SERVICE: Allow reimbursement \$77.99
14040	\$1065.68	\$834.30	\$124.81	1	100%	\$959.11	DISPUTED SERVICE: Allow reimbursement \$124.81

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