

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 24, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001923	<b>Date of Injury:</b>	08/12/2014
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	12/12/214
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	01/21/2015
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	64831, 26350, 26540, 29125, & 99053		

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 \$2,245.88 in additional reimbursement for a total of \$2,495.88. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2,495.88 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
- Official Medical Fee Schedule
- AMA CPT 2014

## 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 rate for 64831, 26350, 26540, 29125, & 99053 Ambulatory Surgical services performed on 08/12/2014.**
- Claims Administrator Reimbursement Rational for CPT 29125: “Per CCI Edits, this procedure is included in the value of of a comprehensive or mutually exclusive procedure billed on the same day.”
- CPT 29125 Apply forearm splint, has been a bundled service to billed procedure code 64831 suture of digital nerve, hand or foot; 1 nerve, since 1999 and is not separately reimbursable.
- Claims Administrator Reimbursement Rational for CPT 99053: “This code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the Provider’s Jurisdiction.”
- CPT 99053 Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service, is a 2014 Status Indicator “B” and is not reimbursable under OPFS.
- Claims Administrator Reimbursement Rational for **CPT 64831, 26350, 26540:** “Recommended payment reflects Physician Fee Schedule Surgery Section, rule 7 guidelines for multiple or bilateral surgical services.”
- UB-04 reflects Bill Type 831
- No Contractual Agreement as per Provider. EOR for date of service in question does not reflect PPO discount applied.
- Payment pursuant to C.C.R. §9789.33, Outpatient Facility Fee Schedule
  - 64831 Wt. 39.4068

- 26350 Wt. 30.6686 MPPR Applies
  - 26450 Wt. 17.2090 MPPR Applies
  - 29125 Bundled Procedure
  - 99053 Bundled Procedure
  - Adjusted Conv. Factor \$80.45
  - WC Multiplier 0.82
  - Formula: APC Relative Weight x Adj Conversion Factor x WC Multiplier
- Based on the formula pursuant to C.C.R. §9789.33, it appears the Claims Administrator's Calculations are incorrect.
  - Additional reimbursement is warranted for 64831, 26350, 26540 Ambulatory Surgical Service.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 64831, 26350, 26540, 29125, & 99053**

<b>Date of Service:</b> 08/08/2014							
<b>Ambulatory 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>
64831	\$2599.63	\$1,243.39	\$1,356.24	N/A	1	\$1,356.24	OMFS Refer to Analysis
26350	\$1011.59	\$438.07	\$573.52	N/A	1	\$573.52	OMFS Refer to Analysis
26540	\$567.63	\$251.51	\$316.12	N/A	1	\$316.12	OMFS Refer to Analysis
29125	\$90.96	\$0.00	\$90.96	N/A	1	\$0.00	OMFS Refer to Analysis
99053	\$395.00	\$0.00	\$395.00	N/A	1	\$0.00	OMFS Refer to Analysis

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