

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 3, 2015



IBR Case Number:	CB15-0000346	Date of Injury:	8/26/2014
Claim Number:	[REDACTED]	Application Received:	03/11/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	4/10/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	26320, 26320-51 and 26320-51		

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 \$195.00 for the review cost and \$1,022.63 in additional reimbursement for a total of \$1,217.63. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1217.63 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

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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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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: Reimbursement of CPT 26320, 26320-51 x 2 units.**
- Provider billed the disputed CPT codes on a UB04, bill type 831 for date of service 11/11/2014.
- Claims Administrator reimbursement rationale: “Pre-Authorization Required, Reimbursement Denied.”
- Authorization Letter was submitted as part of the IBR documentation.
- K-wire removal left middle finger was authorized to be performed between 10/28/2014 and 1/28/2015. Provider listed on the Authorization letter is doing business as/or the same entity as billing Provider.
- Services performed at the Surgery Center were authorized by the Claims Administrator.
- UB-04 reflects three line items billed as 26320, 26320-51 x 2 units.
- The medical record did not substantiate the billed codes.
- The Operative Report documented “removal of three Kirschner Wires, left middle finger.”
- The medical record documented the level of service provided and described under CPT 20670.

- The code descriptors for CPT codes 20670 (removal of implant; superficial...) and 20680 (removal of implant; deep...) do not define the unit of service. CMS allows one unit of Service for all implants removed from an anatomic site. This single unit of service includes the removal of all screws, rods, plates, wires, etc. from an anatomic site whether through one or more surgical incisions. An additional unit of service may be reported only if implant(s) are removed from a distinct and separate anatomic site.
- Based on the aforementioned documentation and guidelines, reimbursement is indicated for 20670 x 1.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code 20670.

Date of Service: 11/11/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
26320 (allowed as 20670)	\$ 1040.60	\$ 0.00	\$ 1040.60	N/A	\$ 1022.63	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$.1022.63 recommended.
26320-51	520.30	\$0.00	\$520.30	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
26320-51	520.30	\$0.00	\$520.30	N/A	\$0.00	DISPUTED SERVICE: See Analysis.

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