

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 5, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000369	Date of Injury:	04/02/2011
Claim Number:	[REDACTED]	Application	03/09/2015
Assignment Date:	04/06/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/16/2014 - 10/16/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	25332, 20922-51 & 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: 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 \$621.91 in additional reimbursement for a total of \$822.91. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$822.91** 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

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 remunerating for 25332, Arthroplasty, wrist, with or without interposition, with or without external or internal fixation 20922-51 Removal of fascia for graft & 29125-51 Apply forearm splint, on 10/16/2014.**
- Claims Administrator reimbursement rational based on “CCI Edits.”
- Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers’ Compensation orders that the physician and non-physician practitioner services fee schedule portion of the Official Medical Fee Schedule contained in title 8, California Code of Regulations, section 9789.19, is adjusted to conform to changes to the Medicare system and Medi-Cal rates.
- 1 code pair found in Hospital APC Version 20.3 (10/1/2014-12/31/2014). The following code pairs generally cannot be reported together: Column 1 - 25332, Column 2 - 29125.
- Medicare Manual, National Correct Coding Initiative Policy, Chapter 1, Page 8, Paragraph 2, “If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment.
- **CPT 29125** reflects a status indicator of “N1” and is packaged into the payment for the main procedure performed (25332).
- EOR indicates the Claims Administrator reimbursed the Provider for the main procedure, Column 1, **25332**, as such, additional reimbursement is not warranted for Column 2 - **29125**.
- §9789.33. Determination of Maximum Reasonable Fee, For services rendered on or after September 1, 2014, APC relative weight x adjusted conversion factor x **0.808** workers’

compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.

- CPT 20922 is a status indicator “T” ASC payment with MPPR applies.
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for CPT Codes 25332 and 20922.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 25332, 20922-51 & 29125-51

Date of Service: 10/16/2014						
ASC Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
25332	\$2,834.44	\$2,353.13	\$197.87	1	\$2,834.44	\$160.54 Due Provider
20922-51	\$1,025.98	\$456.02	\$467.37	1	\$1,025.98	\$467.37 Due Provider
29125	\$90.96	\$0.00	\$81.87	1	\$0.00	Refer to Analysis

Copy to:

██
 ██
 ██

Copy to:

██
 ██
 ██