

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 12, 2015

██████████
████████████████████
████████████████████

IBR Case Number:	CB15-0000385	Date of Injury:	07/08/2014
Claim Number:	██████████	Application Received:	03/16/2015
Claims Administrator:	██████████		
Assigned Date:	4/14/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	25394, 25240, 29844-59		

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 \$195.00 for the review cost and \$1265.66 in additional reimbursement for a total of \$1460.66. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1460.66 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: ██████████

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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: Provider seeking full reimbursement for 25394, 25240 and 29844-59.**
- Provider billed the disputed CPT codes on a UB04, bill type 831 for date of service 11/07/2014.
- In addition to the disputed codes the Provider also billed CPT 29846. Claims Administrator reimbursed the Provider \$2,317.46 for the billed code 29846.
- Operative procedures performed: Left wrist ulnocarpal impaction with TFCC tear, chondromalacia of the lunate, and synovitis of the ulnocarpal joint.
- CPT 29844 is generally not separately reimbursable when billed with the more extensive procedure 29846. The synovectomy procedure documented in the operative was not distinct or separate from the more extensive procedure 29846. Reimbursement is not recommended for CPT 29846.
- CPT 25394: Osteoplasty, carpal bone, shortening. The Operative report did not substantiate the billed code. Procedure not documented in operative report.
- CPT 25240: Excision distal ulna partial or complete. The operative report documented a “standard distal ulna wafer resection was then performed.”
- Procedure performed arthroscopically, not documented as an open procedure. Recommended code for arthroscopic procedure is 29999. CPT 29999 is a By-Report code; therefore, reimbursement is recommended based on a comparable code 25240.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code L3660

Date of Service: 10/2/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
25394	\$ 5109.24	\$ 0.00	\$ 3,772.84	N/A	\$ 0.00	DISPUTED SERVICE: See Analysis. Service not documented as performed.
29999 (billed as 25240)	\$3,500.00	\$0.00	1,265.66	50%	\$1265.66	DISPUTED SERVICE: See Analysis. Reimbursement recommended based on comparable code 25240
29844	\$3,500.00	\$0.00	1,158.73	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
29848	\$4,000.00	\$2,317.46	N/A	N/A	N/A	NOT A DISPUTED SERVICE

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