

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 16, 2015

[REDACTED]

IBR Case Number:	CB15-0000954	Date of Injury:	08/25/2014
Claim Number:	[REDACTED]	Application Received:	06/11/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/25/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	12002-59, 29515-LT, 90471, 96372-59		

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 \$153.48 in additional reimbursement for a total of \$348.48. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$348.48 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: [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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: Mediregs 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 is dissatisfied with denial of codes 12002-59, 29515-LT, 90471, 96372-59
- Claims Administrator denied codes 96372 and 90471 indicating on the Explanation of Review “This code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the provider’s jurisdiction”
- 96372 - Therapeutic, prophylactic, or diagnostic injection (**specify substance or drug**); subcutaneous or intramuscular.
- Provider’s report documents “Injection for antibiotics given with oral Norco for pain control”. Provider does not document the specific substance or drug for the therapeutic, prophylactic, or diagnostic injection and therefore, reimbursement of 96372 is not warranted.
- 90471 -Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
- Provider documents “Tetanus vaccination given in ER”
- 90471 has a status indicator of ‘S’ - Procedure, Not Discounted when Multiple. Paid under OPPS; Separate APC payment. Reimbursement of 90471 is warranted.

- Claims Administrator also denied code 12002 indicating on the Explanation of Review “This charge is denied as the facility did not bill the appropriate HCPCS code. Please provider the HCPCS code for the item billed.”
- 12002 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
- Report submitted states “Puncture wound with 2cm laceration to Left Lower Leg... Would irrigated and cleaned closed using nylon sutures”
- Documentation does not support billed code. Therefore, reimbursement of 12002 is not warranted.
- Claims Administrator denied code 29515 indicating “This charge is denied as the facility did not bill the appropriate HCPCS code. Please provider the HCPCS code for the item billed.”
- 29515 - Application of short leg splint (calf to foot)
- Documentation reviewed states “A short leg splint was applied to Left Lower Leg with crutches and training.”
- Based on documentation reviewed, reimbursement of 29515 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 90471 and 29515

Date of Service: 08/25/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
90471	\$114.00	\$0.00	\$23.15	1	\$23.15	DISPUTED SERVICE: Allow reimbursement \$23.15
29515	\$295.00	\$0.00	\$130.33	1	\$130.33	DISPUTED SERVICE: Allow reimbursement \$130.33

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