

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 18, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000654	Date of Injury:	01/23/2011
Claim Number:	[REDACTED]	Application Received:	04/20/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/20/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	85018, 14021, and 93005		

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 \$2,204.42 in additional reimbursement for a total of \$2,399.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2,399.42 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]
[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: 95% PPO Reimbursement
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 reimbursement of billed codes 85018, 14021, and 93005 performed on date of service 10/20/2015
- Claims Administrator denied services with rationale “we cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible”
- Provider’s Operative Report submitted documents “Contracture release, adjacent tissue rearrangement 20 cm²” with the description of the procedure to the right medial knee contracture for date of service 10/20/2015.
- 14021: Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
- Reimbursement of 14021 is warranted.
- Per NCCI Edit, a pair code between 93005 and 14021 does exist. Modifier indicator column shows ‘1’ which would allow a modifier to append to the column 2 code.
- Provider did not append a modifier. Reimbursement of 93005 is not warranted.
- CPT 85018 has a status indicator of ‘N’.
- CMS Addendum D1, Proposed Payment Status Indicator N: Items and Services Packaged into APC Rates. Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

