

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 19, 2016

[Redacted]

IBR Case Number:	CB16-0000704	Date of Injury:	09/26/2011
Claim Number:	[Redacted]	Application Received:	04/28/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	12/02/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29848-LT, 64718-LT, 26055-LT, and 20550-59LT		

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 \$3,621.95 in additional reimbursement for a total of \$3,816.95. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3,816.95 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: N/A
- 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 remuneration of billed codes 29848-LT, 64718-LT, 26055-LT, and 20550-59LT performed on date of service 12/02/2015
- Claims Administrator denied all codes with rationale “diagnosis was invalid for the date(s) of service reported”
- Authorization dated 11/12/2015 from Claims Administrator documents “The purpose of this letter is to confirm authorization for the requested medical services noted below:
 1. Wrist endoscopy/surgery 29848
 2. Revise ulnar nerve at elbow 64718
 3. Incise finger tendon sheath 26055
 4. Physical Therapy Quantity: 8 (2x4 left long finger)
 5. Physical Therapy Quantity: 8 (2x4 left elbow)
 6. Physical Therapy Quantity: 8 (2x4 left wrist)

*Documentation shows date range between 11/12/2015 and 1/11/2016.

*Diagnosis not documented on authorization.

- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- Authorization dated 11/12/2015 is contract in nature.
- Provider submitted Operative Report which documents services performed on the injured worker's left wrist and left finger. Report included diagnosis: Left carpal tunnel syndrome, left cubital tunnel syndrome, left long finger trigger digit and left ring finger trigger digit.
- Ambulatory Surgical Centers surgical procedures, 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).
- Pursuant chapter 4 of the National Correct Coding Initiative Policy Manual for Medicare Services: Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For example, CPT codes **20526-20553** (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) should not be reported for the administration of local anesthesia to perform another procedure.
- Reimbursement of 20550 is not warranted.
- Opportunity for Claims Administrator to Dispute sent on 4/29/2016. A response was not received for this review.
- Based on aforementioned documentation and guidelines, reimbursement of 29848, 64718 and 26055 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 29848, 64718 and 26055

Date of Service: 12/02/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery Reduction	Workers' Comp Allowed Amt.	Notes
29848, 64718 & 26055	\$13,665.00	\$0.00	\$3,727.74	Yes	\$3,621.95	Refer to Analysis

National Correct Coding Initiative information:

File	Column 1	Column 2	CCI Description
Hospital APC Version 21.3	26055	20550	Misuse of column two code with column one code.

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

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