

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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 Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

8/11/2014

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 ██████████

IBR Case Number:	CB14-0000171	Date of Injury:	5/3/2013
Claim Number:	██████████	Application Received:	2/7/2014
Claims Administrator:	██████████		
Date(s) of service:	5/3/2013 – 5/3/2013		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	12001		

Dear ██████████:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/7/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$61.20, for a total of \$396.20.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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 or negotiated contract: OMFS
- Other: Current Procedural Terminology (CPT) 1997 guidelines, OMFS Physicians Services

Supporting Analysis:

The dispute regards the denial of a surgical procedure (12001) performed on date of service 5/3/2013. The Claims Administrator denied the billed CPT code 12001 with the explanation “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”

- **CPT 12001*** - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet): 2.5 cm or less.

The (*) affixed to the CPT code denotes the following as per CPT 1997: “The global surgical package concept in CPT includes the pre-operative, intra-operative, and post-operative surgical services. Starred and "add-on" procedures are exempted from the global surgical package concept.”

Upon review of the First Report of Injury, the injured worker was evaluated by the Provider as a new patient with a laceration to the “right middle finger” determined by the treating physician to be “1.5 cm” in length. During the exam, the patient’s review of systems was discussed as well as past, present, family and social history. Three (3) “Finger Right” radiological views were performed, a “Tdap 0.5cc” injection was administered to the “left deltoid” intramuscularly and the laceration was treated, sutured and dressed as per the documentation as follows: “a surgical tray with t-ring was prepared using aseptic technique. Local anesthesia was administered with: 3 mls, 2% Lidocaine without epinephrine. The area was cleansed with NSS and Betadine. The wound was explored and tissue damage assessed. The contaminated wound had additional irrigation applied. Skin depth debrided: Full Thickness. Non-surgical debridement was performed on the non-infected tissue. Proximal tissue was undermined to facilitate proper wound closure. Sutures were placed. There were 5 skin sutures placed, using prolene/surgipro blue 4-0, in an interrupted fashion. Good hemostasis was obtained. Antibiotic ointment was applied to the wound. Estimated blood loss was negligible. A sterile dressing was applied. The patient experienced complications during the procedure.”

The Provider billed and was reimbursed for a new patient evaluation and management code 99204 Modifier 25.

- **99204:** Office or outpatient visit for the evaluation and management of a new patient, which requires three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.
- **Modifier 25:** Current Procedural Terminology (CPT) 1997 guidelines state the following: “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure or other service that was performed. This circumstance is reported by adding the modifier -25 to the appropriate level of E/M service.”

Current Procedural Terminology (CPT) 1997 guidelines state the following: “Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a

Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure or other service that was performed. This circumstance is reported by adding the modifier -25 to the appropriate level of E/M service."

When analyzing the Physician's First Report of Injury for this case, noting the wound assessment, closure and treatment as well as the new patient evaluation and management performed, against the guidelines stipulated in the Current Procedural Terminology (CPT) 1997 code book, a -25 modifier affixed to the E/M code would support the need in reporting CPT Code 12001 as a separate and identifiable service. The billed CPT code 12001 is not included in the value of the billed CPT E/M code 99204; therefore, reimbursement is warranted for the billed CPT code 12001.

MAXIMUS requested a copy of the PPO contract. A copy of the PPO contract was not received by MAXIMUS. The recommended allowance for CPT code 12001 was calculated based on the OMFS Physicians Services Fee Schedule.

Reimbursement of \$61.20 is warranted per the Official Medical Fee Schedule code 12001.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
12001	1	\$122.40	\$61.20	\$0.00	\$61.20	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 12001 (\$61.20) for a total of \$396.20.

The Claims Administrator is required to reimburse the provider \$396.20 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division

of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

[REDACTED] RHIT

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