

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001241	Date of Injury:	04/20/2013
Claim Number:	[Redacted]	Application Received:	09/02/2014
Claims Administrator:	[Redacted]	Assignment Date:	10/07/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	14040		

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 \$250.00 for the review cost and \$426.27 in additional reimbursement for a total of \$676.27. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$676.27 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,

[Redacted]
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:
- National Correct Coding Initiatives
- Other: Physician Services; §9789.16.5 Surgery – Multiple Surgeries and Endoscopies

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 reimbursement of CPT 14040 - Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq. cm or less
- Claims Administrator reimbursed code 50% of billed charge indicating on the Explanation of Review “In accordance with the California Official Medical Fee Schedule, Section 9789.15.5, this service was reduced due to the Multiple Surgery Rule.”
- §9789.16.5 Surgery – Multiple Surgeries and Endoscopies: The following procedures apply when billing for multiple surgeries by the same physician on the same day. - Report the more major surgical procedure without the multiple procedures modifier “-51.” Report additional surgical procedures performed by the surgeon on the same day with modifier “-51.” Rank the procedures subject to the multiple surgery rules (indicator “2”) in descending order by fee schedule amount and apply the appropriate reduction to this code: (A) 100 percent of the fee schedule amount for the highest valued procedure; and (B) 50 percent of the fee schedule amount for the second through the fifth highest valued procedures.

- Provider submitted codes in order on CMS 1500: 14040, 26567-51, 26525-51 and 26445-51. Explanation of Review does not show the highest valued procedure paid at 100%, or any of the billed procedures reimbursed at 100%.
- As Provider was not reimbursed properly for the highest valued procedure billed, CPT 14040 is warranted additional reimbursement based on OMFS.
- PPO Contract was received and a 10% is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code 14040 is warranted.

Date of Service: 3/25/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
14040	\$1065.68	\$532.84	\$532.84	1	100%	\$959.11	DISPUTED SERVICE: Allow reimbursement \$426.27

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