

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 16, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001301	<b>Date of Injury:</b>	01/23/2014
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	09/08/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	10/01/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	20680-51		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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: OMFS, CPT 2014 Guidelines

## 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 code 20680-51, Removal of implant; **deep** (e.g., buried wire, pin, screw, metal band, nail, rod or plate).
- Claims Administrator denied code 20680 indicating on the Explanation of Review “Removal of hardware used for a specific fracture type – regardless of the number of screws, plates, rods or incisions – would only be coded once per CPT guidelines. No additional allowance is recommended.”
- Per CMS’ Medically Unlikely Edits, CPT 20680 has a value of ‘2’. Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding system/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary. Therefore, CPT 20680 may be reported twice. However, documentation must demonstrate support of the procedure.
- Based on review of the operative report, Provider documents “Attention was turned to the right index finger. One K-wire was **palpated just below the skin** and required a slight puncture to the skin. The K-wire was removed with a needle driver. A 1 cm incision

needed to be made at the volar tip to dissect and retrieve the radial K-wire from the distal phalanx.”

- Per documentation, only one (1) DEEP removal was performed. Therefore, per CPT guidelines, reported 20680 twice was inappropriate and reimbursement of CPT 20680-51 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code 20680-51 is not recommended.**

<b>Date of Service:</b> 3/6/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
20680-51	\$356.09	\$0.00	\$356.09	N/A	Yes	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended

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