

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 4, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000464	Date of Injury:	10/7/2011
Claim Number:	[Redacted]	Application Received:	03/24/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	20690-LT		

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.

IBR Case Assigned: 06/06/2014

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 \$335.00 for the review cost and \$353.21 in additional reimbursement for a total of \$688.21. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$688.21 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]
Chief Coding Reviewer

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: PPO Contract
- National Correct Coding Initiatives
- Other: OMFS, AMA CPT 1997 & 2013.

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 dissatisfied with the denial of CPT code 20690-LT.
- Claims Administrator denied reimbursement indicating on the Explanation of Review: “This procedure code is only reimbursed when billed with the appropriate initial base code.”
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers’ Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers’ Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Provider’s Operative Report was received which documents the patient being treated was injured during a softball game and had sustained an injury of his left ring proximal interphalangeal joint. The billed procedure code 20690 is used to describe the placement of external fixation system (pins or wires in one plane). The Provider billed 20690-LT. Based on a review of the documentation; it appears an external fixation device was placed on one plane of the left finger joint. Operative report states after anesthesia is introduced to the left finger at the metacarpal neck level: “Proximal and then distal drills were used then distal and proximal pins were placed by hand with pin tips protruding just through but not protruding from the palmar cortex. This was carried out under fluoroscopic guidance. The pin handles were then cut. The drill guide was removed. A pin clamp was applied. The excess pin length was then cut. The Digit Widget wrist cuff and the external fixation device with a light single rubber band were applied.”
- Based on documentation reviewed, procedure code 20690-LT was the appropriate code assignment and is due reimbursement.
- PPO Contract was received and a 10% discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, reimbursement of CPT code 20690-LT is warranted for the amount listed below.

Date of Service: 12/12/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
20690-LT	\$1638.81	\$ 0.00	\$ 413.10	1	\$ 353.21	DISPUTED SERVICE: Allow reimbursement of \$353.21

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