

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 23, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001730	Date of Injury:	02/12/2010
Claim Number:	[Redacted]	Application Received:	09/28/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	25295-RT51, 64727-RT51, 64450-RT51, and Q4137		

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 \$1,520.61 in additional reimbursement for a total of \$1,715.61. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,715.61 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]
[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
- 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 is dissatisfied with denial of codes 25295-RT51, 64727-RT51, 64450-RT51, and Q4137
- 64727-RT has a status indicator 'N' - Packaged service/item; no separate payment made, for date of service 3/19/2015.
- Reimbursement of 64727 is not warranted.
- Provider billed code 64450-RT, Injection, anesthetic agent; other peripheral nerve or branch.
- Documentation does not specify nerve or branch to support billed code 64450.
- Reimbursement of 64450 is not warranted.
- Provider billed code 25295, Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon, along with 25101 which was reimbursed.
- As a pair code does exist between billed codes 25292 and 25101, status indicator column does show '1' which states that if an approved modifier is appended to the column 2 code, and documentation is submitted to support billed code, then the edit may be overridden. Provider appended approved modifier –RT.
- Documentation submitted states “There was extensive adhesions and scarring of the median nerve and flexor tendons. Median nerve neurolysis was performed using loupe magnification was used along the tenolysis of the flexor tendons”

- Documentation supports billed code 25295-RT for two tendons. Therefore, reimbursement of 25295 is warranted.
- The last code in dispute is Q4137, Amnioexcel or biodexcel, **per square centimeter**.
- Provider’s Operative Report documents “Amnio Clarix Cord was applied by wrapping the median nerve to help prevent recurrent effusions, adhesions and scarring”
- Per code description “per square centimeter” is not documented in report and does not support billed code.
- Based on information reviewed, reimbursement of Q4137 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 25292-RT

Date of Service: 03/19/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
25292 x 2	\$4750.00	\$0.00	\$1461.11	50%	\$1520.61	DISPUTED SERVICE: Allow reimbursement \$1520.61

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 21.0	25101	25292	Allowed

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