

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 4, 2016



IBR Case Number:	CB15-0002186	Date of Injury:	02/12/2010
Claim Number:	[REDACTED]	Application Received:	11/30/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/23/2015 – 04/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64721-LT51, 64727-LT, 25295-LT51, 25295-LT, 64450-LT50, and Q4137-LT22		

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,

Paul Manchester, MD MPH

Medical Director

cc: [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
- National Correct Coding Initiatives
- Other: Outpatient Hospital and Ambulatory Surgery Center Fee Schedule

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:** The Provider is disputing the denial of CPT 64721-LT-51; 64727-LT; 25295-LT-51; 25295-LT-51; 64450-LT-51 and Q4137-LT-22.
- In addition to the disputed codes the Provider billed the following CPT codes: 64890-LT-22; 25101-LT-51-52; 13160-LT-51-59; 99354; 99070 x 2.
- All procedures performed on date of service 4/23/2015.
- If a provider submits two codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 1(C1) code is eligible for payment and the Column 2(C2) code is denied. However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment. Supporting documentation must be in the beneficiary's medical record.
- NCCI Procedure-to-Procedure (PTP) code pair edits exist between the following codes: 13160(C1):64450(C2); 25101(C1):64450(C2); 25101(C1):25295(C2), 25101(C1):64721(C2); and 64890(C1):64450(C2).
- The medical record did not indicate the procedures 64450, 25295 and 64721 were performed at separate patient encounters or separate anatomic locations from the primary procedures (13160, 64890 and 25101). All procedures performed on the left wrist.
- Reimbursement not recommended for CPT codes: 64450, 25295 and 64721.
- Pursuant to Title 8, CCR Section 9789.32 (a) (1) For services rendered on or after September 1, 2014: the item has a status code N, Q1, Q2, or Q3 and is packaged into the

APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).

- CPT/HCPCS codes Q4137 and 64727 are Status Indicators “N” codes.
- “N” Items and Services Packaged into APC Rates. Paid under OPPTS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
- Reimbursement is not recommended for CPT/HCPCS Q4137 and 64727. Reimbursement for these services is included into the payment for the primary surgical procedures.
- Based on the submitted documentation, no additional reimbursement is due.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement not recommended for codes: 64721-LT-51; 64727-LT; 25295-LT-51; 25295-LT-51; 64450-LT-51 and Q4137-LT-22.

Date of 4/23/2015							
Outpatient Hospital Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64721-LT-51	\$4750.00	\$0.00	\$631.34	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
64727-LT	\$4750.00	\$0.00	\$631.34	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
25295-LT-51	\$4750.00	\$0.00	\$730.56	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
25295-LT-51	\$4750.00	\$0.00	\$730.56	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
64450-LT-51	\$375.00	\$0.00	\$730.56	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
Q4137-LT-22	\$2593.50	\$0.00	\$2593.50	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
64890	\$9875.00	\$2391.41	N/A	N/A	N/A	N/A	CODE NOT IN DISPUTE
25101	\$4750.00	\$1075.51	N/A	N/A	N/A	N/A	CODE NOT IN DISPUTE
13160	\$3600.00	\$572.51	N/A	N/A	N/A	N/A	CODE NOT IN DISPUTE

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