

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 11, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001806	Date of Injury:	07/24/2014
Claim Number:	[REDACTED]	Application Received:	11/24/2014
Claims Administrator:	[REDACTED]	Assignment Date:	01/06/2015
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	35761-51, 35761-51, 29125-51		

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,

Paul Manchester, M.D., M.P.H.
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

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 seeking remuneration for 35761-51, 35761-51, and 29125-51 Ambulatory Surgical services performed on 07/24/2014.**
- Claims Administrator Denied Services with the following rationale: “This procedure is included in another procedure performed on this date.
- Charges submitted with UB-04, bill type “831,” Ambulatory Services.
- UB-04 and abstracted information from Operative Report indicates main procedure for a “Small Finger Complex Laceration,” right, as CPT 64831, Suture of digital nerve, hand or foot; 1 nerve.
- AMA CPT 2014 Code Description for services in question:
 - CPT 35761 Exploration (**not followed by surgical repair**), with or without lysis of artery; other vessels.
 - CPT 29125 Application of short arm splint (forearm to hand); static
- **CPT 35761** is a status “T” indicator and is subject to separate ASC payment if the procedure is able to stand alone. The main surgical repair is 64831; performed to repair the right radial and ulnar nerves. CPT 35761 dictates exploration cannot be followed by a surgical repair. As such, CPT 35761 is incorporated into the value of CPT 64831.
- **Modifier -51:** Multiple Procedures (AMA CPT 2014)
- Under certain circumstances, procedures that are typically considered mutually exclusive can be unbundled. When the value of one procedure is clearly documented as separate from its normally coded pair, appending Modifier -59 (Distinct Procedural Service) in addition to supporting documentation, to the second code in the pair will allow each code to stand alone. CPT 35761 is a Colum 2 code to CPT 64831. Submitted UB-04 reflects

two entries for CPT 35761 with Modifier -51 appended to each. As such, CPT 35761 cannot be reviewed as independent procedure from its code pair, CPT 64831.

- **CPT 29125** is a “packaged service item” and is included in the service of the main procedure, CPT 64831.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement cannot be recommended for CPT Codes: 35761-51, 35761-51, 29125-51

Date of Service: 07/24/2017						
Hospital Outpatient Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
35761-51	\$1,292.06	\$0.00	\$1,292.06	N/A	\$0.00	Refer to Analysis
35761-51	\$1,292.06	\$0.00	\$1,292.06	N/A	\$0.00	Refer to Analysis
29125-51	\$90.96	\$0.00	\$90.96	N/A	\$0.00	Refer to Analysis

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