

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 11, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000387	Date of Injury:	03/06/2012
Claim Number:	[REDACTED]	Application Received:	03/16/2015
Assignment Date:	04/14/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/25/2014 – 11/25/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	20526-59-RT		

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 \$128.13 in additional reimbursement for a total of \$323.13. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$323.13** 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, M.D., M.P.H.
Medical Director

MAXIMUS FEDERAL SERVICES, INC.

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



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
- OMFS

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 full remuneration for 20526-59-RT Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel performed on 11/25/2014.**
- Claims Administrator reimbursement rational: “Service included in the value of another service performed.”
- **§ 9789.12.1** Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014
§9789.12.13 Correct Coding Initiative (a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. **Except where payment ground rules differ** from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
- OMFS Surgery Ground Rules, pages 123 through 124, do not list disputed CPT 20526, as such Medicare Ground Rules apply.
- National Correct Coding Initiative Policy Manual for Medicare, Chapter IV, Surgery, Musculoskeletal System, page 6, paragraph 2: Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For

example, CPT codes 20526-20553 (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) should not be reported for the administration of local anesthesia to perform another procedure. The NCCI contains many edits based on this principle. **If a procedure and a separate and distinct injection** service unrelated to anesthesia for the former procedure are reported, the injection service may be reported with an NCCI-associated modifier if appropriate.

- Procedure Report indicates two distinct injections unrelated to procedure.
 - Right Trigger Thumb
 - Right Carpal Tunnel Ulnar
- CMS 1500 form indicates the appropriate modifier was utilized.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for CPT 20526-59-RT**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 20526-59-RT

Date of Service: 11/25/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
20526-59-RT	\$180.00	\$0.00	\$128.13	N/A	1	\$128.13	Refer to Analysis

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]

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