

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 29, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000221	Date of Injury:	10/17/2012
Claim Number:	[REDACTED]	Application Received:	02/16/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/15/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	27690, 28285 x 4, 28645 x 3, and 28645		

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 \$3,848.58 in additional reimbursement for a total of \$4,043.58. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$4,043.58 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

[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: 10% PPO Discount
- 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 seeking remuneration of codes 27690 , 28285 x 4, 28645 x 3, and 28645 performed on date of service 10/15/2015.
- Provider states a 90% reimbursement rate is in agreement between the two parties.
- Claims Administrator's reimbursement rationale "The amount is based on the reimbursement rate with the PPO network." **EOR received reflects a 10% discount was applied to reimbursement. Claims Administrator does not dispute a 90% reimbursement rate.**
- Provider denied billed code 28645 x 3 units entirely and reimbursed 1 unit.
- Provider's Operative Report documents: "we reduced the DIP and PIP joints and pinned them in neutral position with a 2.0 K-wire and then reduced the MTP joint tendon with a 2.0 K-wire as well." Provider states the "Open reduction of the metatarsophalangeal joint" was performed on each toe during this procedure.
- 28285 AMA CPT Assistant: **the insertion of K-wire through DIP, PIP, and MTP joints are all inclusive components of the procedure described by code 28285, Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy), and should not be reported separately.**
- Reimbursement of 28645 x 4 is not warranted.
- Both 27690 and 28285 have status indicator 'T': Paid under OPPS; separate APC payment.

- **Section 9789.38. Appendix X, 42 C.F.R. § 419.44:** (a) multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on --
 - (1) **The full amounts for the procedure with the highest APC payment rate;** and
 - (2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.
- 28285: weight 23.1692 x cf 87.33 x 1.212 = 2452.32 / 50% (MPRP) = \$1226.16 per unit. \$1226.16 x 4 units = 4,904.64 x 90% PPO discount = \$4,414.18
- Claims Administrator reimbursed \$1,108.45 x 4 units of 28285 = \$4,433.80
- No further reimbursement is owed for 28285 x 4 units.
- HCPCS 27690 has the highest APC weight and is reimbursed at 100%.
 - Weight 52.0371 x 87.33 x 1.212 = 5507.81 x 90% = **\$4957.03**
- Based on aforementioned documentation and guidelines, additional reimbursement of 27690 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 27690, 28285 x 4, 28645 x 3, and 28645

Date of Service: 10/15/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
27690	\$4303.09	\$1108.45	\$4399.36	100%	\$4957.03	\$3,848.58 Due to Provider
28285 x 4	\$4303.09 each	\$4433.80 total 4	\$470.84	50%	\$4,414.18	Refer to Analysis

[REDACTED]

[REDACTED]