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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 12, 2014

[redacted]

IBR Case Number:	CB14-0001007	**Date of Injury:**	8/27/2013
Claim Number:	[redacted]	**Application Received:**	7/16/2014
Claims Administrator:	[redacted]	**Assignment Date:**	8/18/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	97018-59		

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,

[redacted]
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
- Negotiated contracted rates: PPO Contract Discount 7%
- National Correct Coding Initiatives
- Other: OMFS Physician 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 is dissatisfied with denial of CPT code 97018-59.
- Based on the NCCI edits that exist with code 97018, generally CPT 97018 is not reported with 97140(a billed code by the Provider for the same patient visit). However, Modifier Indicator column is showing a '1' which allows a proper modifier appended to the correct code to override the NCCI Edit with supportive documentation.
- Modifier 59: "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. **Documentation must support** a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of

NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. Carrier (A/B MAC processing practitioner service claims) processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used

- Provider submitted chart notes with no description of 97018 or reason for the modality. Documentation does not support the reimbursement for CPT 97018-59 and Claims Administrator was correct to deny payment.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of CPT code 97018-59 is not warranted.

Date of Service: 3/14/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
97018-59	$40.00	$0.00	$7.99	N/A	N/A	$ 0.00	**DISPUTED SERVICE**: No reimbursement recommended

National Correct Coding Initiative information:

File	**Column 1**	**Column 2**	**Modifier**
Physician Version Number: 20.0 1/1/2014-3/31/2014	97140	97018	Modifier Allowed

Copy to:

[redacted]

Copy to:

[redacted]