

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 23, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001685	Date of Injury:	06/03/2014
Claim Number:	[REDACTED]	Application Received:	11/10/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	12/10/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	13121 and 29130-51		

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,

[REDACTED]  
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
- Negotiated contracted rates:
- 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 is dissatisfied with denial of codes 13121 and 29130-51.
- Claims administrator denied codes indicating on the Explanation of Review “Per the NCCI Outpatient Code Editor, your services have been disallowed.”
- Provider billed codes 13121, 29130-51 and 11760-51 on a UB-04 CMS 1450 form.
- Per NCCI Edits, generally codes 11760 and 13121 are not reported together. However, Modifier Indicator column shows ‘1’ which states if the appropriate modifier is appended to the proper CPT code and documentation is submitted to support the code, then the edit may be overridden. The same goes for codes 11760 and 29130 as well as 29130 and 13121 not generally reported together.
- Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI; Global surgery modifiers: 24, 25, 57, 58, 78, 79; Other modifiers: 27, 59, 91
- Provider submitted codes 11760 and 29130 with a modifier -51 which is not one of the approved modifiers to append for the edits. CPT 13121 was not billed with a modifier.
- Based on information reviewed, claims administrator was correct to deny codes 13121 and 29130-51 as they were not billed correctly according to coding guidelines. Therefore, reimbursement of codes 13121 and 29130-51 is not warranted.

