MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 10, 2016

[redacted]

IBR Case Number:	CB16-0000641	Date of Injury:	07/09/2015
Claim Number:	[redacted]	Application Received:	04/19/2016
Claims Administrator:	[redacted]		
Date(s) of service:	12/28/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	78305-59		

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: 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 $293.89 in additional reimbursement for a total of $488.89. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $488.89 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

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: N/A
- 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 code 78305-59 performed on date of service 12/28/2015
- Claims Administrator denied code as "included in 78315 per CCI Edits"
- Based on the NCCI edits:

Column 1	Column 2	CCI Edit Description*	Modifier Indicator	Effective Date*
78315	78305	More extensive procedure	1	1/1/1996

- Accepted modifiers: 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, *XE, XS, XP, XU*
- Provider billed column 2 code with modifier -59.
- **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.

- NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES - L. More Extensive Procedure:
  - The CPT Manual often describes groups of similar codes differing in the complexity of the service. Unless services are performed at **separate patient encounters** or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable
- **Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day**. Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or **diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers** – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.
- Documentation submitted included Provider's report which states "The patient was asked to return 3 hours later for spot planar images of the same region in same views" and "three-hour delayed bone images again demonstrate mild to moderate increased tracer activity…"
- Opportunity for Claims Administrator to Dispute sent on 4/20/2016. A response was not received for this review.
- **Section 9789.32** (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
  - (i) If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.
- PPO contract not submitted for review.
- Based on guidelines and documentation reviewed, reimbursement of 78305-59 is warranted.

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 78305-59

Date of Service: 12/28/2015						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
78305-59	$2,317.00	$0.00	$293.89	N/A	$293.89	**Refer to Analysis**

National Correct Coding Initiative information:

File	**Column 1**	**Column 2**	**Modifier**
Hospital APC Version 21.3	78315	78305	Yes

Copy to:

[redacted]

Copy to:

[redacted]