
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 13, 2016

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

IBR Case Number:	CB16-0000851	Date of Injury:	01/28/2016
Claim Number:	[REDACTED]	Application Received:	05/23/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/03/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	26412-59		

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,

Maximus

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
- Medicare National Correct Coding Policy Manual

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 additional remuneration for 26412-59, Repair, extensor tendon, hand, primary or secondary; with free graft (includes obtaining graft), each tendon, performed on 02/03/2016.**
- The Claims Administrator denied code with rationale “This procedure is included in another procedure performed on this date.”
- Provider billed code along with 11010 on UB04, Place of service “131.”
- As a pair code does exist between reimbursed code 11010 and 26412, Medicare National Correct Coding Policy Manual states the pair as **Mutually Exclusive Procedures**. Many procedure codes cannot be reported together because they are mutually exclusive of each other. **Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter.**
- Multiple approaches to the same procedure are mutually exclusive of one another and should not be reported separately.
- **Modifier -59:** For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. 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.**

- NCCIPTP 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 NCCIPTP 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’s Operative Procedure Report submitted documents “open fracture, proximal phalanx, right middle finger with possible tendon lacerations.” The body of report does not document 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) to support the definition of modifier -59.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is not warranted for 26412-59.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 26412-59

Date of Service: 02/03/2016 HOPPS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
26412	\$52,704.78	\$0.00	\$1,548.33	1	\$0.00	Refer to Analysis

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