
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001280	Date of Injury:	03/14/2012
Claim Number:	[REDACTED]	Application Received:	09/05/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/07/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22554 and 63076		

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
- Other:

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 22554-51.
- Based on the NCCI edits, generally codes 63075 and 22554 cannot be reported together. Modifier Indicator column shows '1', which states that if the proper modifier is appended to the correct code and documentation is submitted to support the modifier, then the edit may be overridden.
- Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled.
- 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
- Provider billed with a -51 modifier which is not an appropriate modifier to override the edit.

- Based on information received, Claims Administrator was correct to deny CPT 22554-51 and therefore reimbursement for code is not recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code 22554-51 is not warranted.

Date of Service: 11/19/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22554-51	\$4763.00	\$0.00	\$1035.48	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 19.3 10/1/2013-12/31/2013	63075	22554	Allow Modifier

Copy to:

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

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]