

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 19, 2014

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

IBR Case Number:	CB14-0001464	Date of Injury:	05/17/2013
Claim Number:	[REDACTED]	Application Received:	09/29/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/29/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	26180, 29130-51, 29130-51, 26445		

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], RHIT, CCS
Chief Coding Reviewer

cc: [REDACTED]
Division of Workers’ Compensation (DWC) Medical Unit

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: none
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: NCCI Policy Manual, Chapter 4

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:** Denial of CPT codes 26445, 29130-51 and 29130-51.
- Based on the NCCI edits there are two suspect code sets.
- Code 26180 is listed as a Column 1 procedure and Code 26445 is a Column 2 procedure.
- The Provider did not append a modifier to CPT code 26445 indicating that it was distinct from the service reported with CPT code 26180. Furthermore, the operative report does not substantiate that code 26445 was separate and distinct. Therefore the denial of code 26445 was correct.
- The NCCI Policy Manual, Chapter 4 indicates that splints are not reported when applied following a therapeutic procedure. Therefore the denial of CPT codes 29130-51 and 29130-51 were appropriately denied.
- Per CPT Assistant April 2002 page 13 the coding of casts/splints are not reported when a restorative procedure is performed.
- Although a contract is not included in the case file, original reimbursement included application of a 10% discount. Therefore the discount is applied.
- Reimbursement for CPT code 26180 is calculated as follows:
Adjusted CF \$80.45 x APC RW 16.6230 x WC Mult. .82 * .90 = \$986.94

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: No additional reimbursement is due to the Provider. The denial of CPT codes 26445, 29130-51 and 29130-51 was appropriate.

Date of Service: 6/5/14						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Mult Surg	Workers' Comp Allowed Amt.	Notes
26445	\$1135.25	\$0	\$1135.25		\$0	DISPUTED SERVICE: Deny per NCCI edits.
29130-51	\$50.70	\$0	\$50.70		\$0	DISPUTED SERVICE: Deny per NCCI edits.
29130-51	\$50.70	\$0	\$50.70		\$0	DISPUTED SERVICE: Deny per NCCI edits.
26180-51	\$567.63	\$ 1014.67	\$0	100%	\$986.94	DISPUTED SERVICE: No additional reimbursement warranted as paid above the allowable. Correct reimbursement should have been \$986.94.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 19.3	26180	26445	Allowed
Hospital APC Version 19.3	26445	29130	Allowed

Copy to:

[REDACTED]

Copy to:

Division of Workers' Compensation Medical Unit
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