

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 5, 2014

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

IBR Case Number:	CB14-0000538	Date of Injury:	04/27/2013
Claim Number:	[REDACTED]	Application Received:	04/08/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	25118-51, 25000-LT		

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.

IBR Assigned: 06/09/2014

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]

Chief Coding Reviewer

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: none
- 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:** Denial of codes 25118-51, and 25000.
- Based on the NCCI edits the use of code 25000 is suspect when submitted with code 25023. Service code 25023 was reimbursed and the provider did not append an appropriate modifier to indicate that it was separate and distinct from code 25023. The service was done in the same compartment as code 25023 and therefore should not be reimbursed.
- The operative report substantiates reimbursement of code 25118 however 25118-51 was in the same compartment and should not be considered a separate service.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 25118-51 and 25000 should be denied based on the NCCI edit most extensive procedure rule. They were done in same compartment as 25118, which is the most extensive procedure.

Date of Service: 9/9/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Mult Surg	Workers' Comp Allowed	Notes

					Amt.	
25118-51	\$ 5670.30	\$ 0	\$ 2348.83	50%	\$ 0	DISPUTED SERVICE: Deny service as it is a component of primary procedure and not separate and distinct.
25000-LT	\$ 3862.98	\$ 0	Included in above	50%	\$0	DISPUTED SERVICE: Deny service as it is a component of primary procedure and not separate and distinct.
25118	\$ 5670.30	\$ 2137.35	\$ 0	100%	Not in Dispute	Service not in dispute

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 19.2	25118	25000	Allowed
Hospital APC Version 19.2	25023	25000	Allowed
Hospital APC Version 19.2	25118	25111	Allowed

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