

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 30, 2015

██████████  
████████████████████  
████████████████████

IBR Case Number:	CB15-0002224	Date of Injury:	08/12/2013
Claim Number:	██████████	Application Received:	12/03/2015
Claims Administrator:	████████████████████		
Date(s) of service:	06/19/2015		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	26442, 64721, and 26145		

Dear ██████████

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 \$3648.64 in additional reimbursement for a total of \$3843.64. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$3843.64 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: ██████████  
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## 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: PPO Contract Not Available
- National Correct Coding Initiatives

## 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 seeking remuneration of codes 26442, 64721, and 26145 performed on 06/19/2015
- Claims Administrator denied code 26442 indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day,” “in accordance with Clinical Based Coding Edits (National Correct Coding Initiative/Outpatient Code Editor)” and reimbursed 26145 & 64721 with indication “This charge was adjusted to comply with the rate and rules of the contract indicated”
- A copy of the PPO contract was not submitted for review.
- Although a pair code does exist between 26145 and 26442, modifier indicator column shows ‘1’ which states if an approved modifier is appended to the column ‘2’ code, and documentation supports billed code, then the edit may be overridden.
- Provider billed column 2 code 26442 with approved modifier -59.
- Provider’s Operative Report documents procedures performed on 6/19/2015 and supports billed code 26442.
- Based on coding guidelines and documentation reviewed, additional reimbursement is warranted for date of service 6/19/2015.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 26442, 64721, and 26145

<b>Date of Service:</b> 06/19/2015							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
26442, 64721, and 26145	\$24526.00	\$4183.13	\$3648.64	1	Yes	\$7831.77	<b>\$3648.64 Due to Provider</b>

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