

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000480	Date of Injury:	03/03/2014
Claim Number:	[Redacted]	Application Received:	04/02/2015
Claims Administrator:	[Redacted]		
Date Assigned:	4/29/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64721-RT-51 & 26055 F7-51		

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: 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 \$471.79 in additional reimbursement for a total of \$666.79. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$666.79 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: [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: PPO Discount 10%
- 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:** Provider is dissatisfied with denial of code 64721-RT-51 and 26055 F7-51
- Claims Administrator denied codes 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”
- As pair codes exist between billed code 25101 and 64721, and 25101 and 26055, generally these codes are not billed together. However, Modifier Indicator column shows ‘1’ which states that if an approved modifier is appended to the appropriate CPT and documentation supports the use of the code then the edit may be overridden.
- 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; Other modifiers: 27, 59, 91
- 64721 does not have an approved modifier and therefore, reimbursement is not warranted.
- 26055-F7 does have an approved modifier and documentation received supports billed code. Therefore, reimbursement of 26055-F7 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 26055-F7 is recommended.

Date of Service: 11/7/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
26055-F7	\$4750.00	\$0.00	\$556.81	N/A	\$471.79	DISPUTED SERVICE: Allow reimbursement \$471.79

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.3	25101	64721	Allowed
Hospital APC Version 20.3	25101	26055	Allowed

Copy to:

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[REDACTED]