

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 25, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0001972	Date of Injury:	11/15/2012
Claim Number:	[Redacted]	Application Received:	12/22/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/27/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	26055-51		

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: 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,

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:
- 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 26055-51
- Claims administrator denied code indicating on the Explanation of Review “Per the CCI Edits, this procedure is included in the value of a comprehensive or mutually exclusive procedure billed on the same day.”
- Provider billed codes 26440-59-51 and 26055-51 on a UB-04 for date of service 5/19/2014.
- Per NCCI Edits, generally codes 26440 and 26055 are not billed together. However, Modifier Indicator column shows ‘1’ which states that if the correct code is appended by a qualifying modifier and documentation submitted supports code used, then the edit may be overridden. Provider billed code 26055 with a modifier -51.
- Per NCCI Edits on code 26055, 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
- Provider did not append a qualifying modifier and therefore reimbursement of code 26055-51 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 26055-51 is not recommended.

Date of Service: 5/19/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
26055-51	\$567.63	\$0.00	\$567.63	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier Allowed?
Hospital APC Version 20.1	26440	26055	Yes

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