

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 23, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001594	Date of Injury:	11/27/2012
Claim Number:	[Redacted]	Application Received:	10/23/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	07/11/2014 – 07/11/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63047-62-59, 63048-62-59 (3 units), 22214-62-51, 22216-62 (2 units), 22842-62		

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 \$250.00 for the review cost and \$1449.04 in additional reimbursement for a total of \$1699.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1669.04 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,

[Redacted]
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
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule

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 reimbursement of codes: 63047-62-59, 63048-62-59 (3 units), 22214-62-51, 22216-62 (2 units) and 22842--62.
- **The CPT codes 22632, 22612 and 22614 were listed on the IBR application, but not listed on the SBR-1 or appealed with the Claims Administrator; therefore, were not eligible for IBR.**
- Claims administrator reimbursed a partial payment indicating on the Explanation of Review “Reimbursement reflects services provided by Co Surgeons with appropriate percentage apportioned.” If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.” Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the Co-Surgeons (“Co-Surg.”) column of the National Physician Fee Schedule Relative Value File. If the surgery is billed with a “-62” modifier and the Co-Surgeons column contains an indicator of “1,” any documentation submitted with the claim should be reviewed to identify support for the need for co-surgeons. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. If the surgery is billed with a “-62” modifier and the Co-Surgeons column contains an indicator of “2,” payment rules for two surgeons apply. The claims administrator shall base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount.
- Multiple procedure reduction rules may also apply.
- CPT 22612, 63048 and 22842 are not subject to multiple procedures reduction guidelines. They are listed as add-on codes, which are to be reimbursed at 100% of OMFS.

- Based on information reviewed, additional reimbursement on codes is warranted.
- PPO contract reviewed shows a 2% discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes: 63047-62-59, 63048-62-59, 22214-62-51, 22216-62 and 22842-62 is warranted

Date of Service: 07/11/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Co-Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63047-62-59	\$1130.84	\$ 706.78	\$ 424.06	Y	50%	\$ 554.11	DISPUTED SERVICE: No additional reimbursement warranted.
63048-62-59	\$ 214.73	\$ 134.21	\$ 80.52	Y	100%	\$210.44	DISPUTED SERVICE: Additional reimbursement in the amount of \$134.21 recommended.
63048-62-59	\$ 214.73	\$ 134.21	\$ 80.52	Y	100%	\$210.44	DISPUTED SERVICE: Additional reimbursement in the amount of \$134.21 recommended
63048-62-59	\$214.73	\$134.21	\$80.52	Y	100%	\$210.44	DISPUTED SERVICE: Additional reimbursement in the amount of \$134.21 recommended
22214	\$764.39	\$238.87	\$49.12	Y	50%	\$749.10	DISPUTED SERVICE: Additional reimbursement in the amount of \$510.23 recommended
22216	369.26	\$230.79	\$138.47	Y	100%	\$361.87	DISPUTED SERVICE: Additional reimbursement in the amount of \$131.08 recommended
22216	369.26	\$230.79	\$138.47	Y	100%	\$361.87	DISPUTED SERVICE: Additional reimbursement in the amount of \$131.08 recommended
22842	771.90	\$482.44	\$289.46	Y	100%	\$756.46	DISPUTED SERVICE: Additional reimbursement in the amount of \$274.02 recommended

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