

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 16, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001884	Date of Injury:	04/12/2011
Claim Number:	[Redacted]	Application Received:	12/09/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/8/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22554-99-20-22, 22585-22, 63075-22, 63076-22, 22855-22, 22849-22, 22851-22, 22851-99-22-59, 22845-22, 22116-99-22-59, 22110-22, 22116-22, 76001-22, 64830-99-22-20		

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 \$2108.55 in additional reimbursement for a total of \$2358.55. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2358.55 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 Contract Discount 5%
- 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 dissatisfied with reimbursement of codes 22554-99-20-22, 22585-22, 63075-22, 63076-22, 22855-22, 22849-22, 22851-22, 22851-99-22-59, 22845-22, 22116-99-22-59, 22110-22, 22116-22, 76001-22, 64830-99-22-20
- Codes 22554, 22849, 22851, 22585, 22110, 22116 and 22116-59 were all reimbursed based on the OMFS and no further reimbursement is recommended for these codes.
- Provider also billed with a modifier -22 for increased procedure. Provider's operative report was reviewed by a Maximus medical director who concluded that the modifier -22 was appropriate for code 22554 but not for any of the other codes billed. Therefore, additional reimbursement for modifier -22 is not warranted. Penalties and interest are not something Maximus reviews for reimbursement.
- Current Procedural Terminology (CPT) 1997. The CPT 76001 is separately reported when billed with the OMFS surgical procedures codes listed above. The Provider submitted an operative report and a separate fluoroscopy report. The procedure code 76001 is listed as a "By Report" code; therefore, the allowance was based on a code comparable in complexity, scope and description. The allowance was calculated based on procedure code 76000. The description of procedure code 76000 is "Fluoroscopy (separate procedure), up to one hour physician time."

- The disputed procedure code 64830 is payable for microscope use with nerve dissection or repair and is reimbursed 50% of the primary procedure. The Provider documented the use of a microscope for the spinal nerve root damage and spinal cord injury procedures. The operative report documented a neurolysis of the nerve root at C7. Reimbursement is warranted for the billed procedure code 64830. The allowance for the procedure code 64830 is based on 50% of the allowance for the billed primary procedure code 22554
- The billed osteotomy procedure code 22110 describes a removal of a portion of vertebral segments. The operative report documented an anterior osteophyctomy at C6/C7, superior and inferior parts of vertebral bodies of C6 and C7. The osteotomy procedure code 22110-59 is not used to report an osteophyctomy. The procedure codes 63075 and 63076 are used to report the removal of intervertebral disc(s) and osteophytes. The description of CPT 63075 is “Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace.” The description of CPT 63076 is “Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace.” Reimbursement for procedure codes 63075 and 63076 is warranted. Claims administrator reimbursed 22849 at 50% as the secondary procedure. CPT 63075 has a higher value and is to be reimbursed as the second highest procedure less the amount over reimbursed for code 22849.
- Codes 22845 and 22855 were also billed by provider. 22855 is removal of anterior instrumentation and 22845 is insert spine fixation device. Operative report states provider inserted a plate and screws then removed the plate as it was not fitting properly then reinserted a properly fitting plate. Provider billed code 22849 which is reinsertion of spinal fixation device. As the patient did not go into the procedure with instrumentation to be removed but rather had it inserted, code 22855 is not appropriately billed. Claims administrator reimbursed 22849 and therefore no further reimbursement for 22845 and 22855 is warranted.
- Based on information reviewed, reimbursement of codes 76001, 64830, 63076 and 63075 is warranted.
- PPO contract received shows a 5% discount is to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 76001, 64830, 63076 and 63075 is recommended.

Date of Service: 11/5/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
76001	\$3000.00	\$0.00	\$3000.00	N/A	N/A	\$72.20	DISPUTED SERVICE: Allow reimbursement \$72.20
64830	\$1271.81	\$0.00	\$1271.81	N/A	50%	\$1216.86	DISPUTED SERVICE: Allow reimbursement \$1216.86
63076	\$2359.00	\$0.00	\$2359.00	N/A	100%	\$745.65	DISPUTED SERVICE: Allow reimbursement \$745.65
63075	\$6253.00	\$0.00	\$6253.00	N/A	50%	\$966.58 – 892.74 = 73.84	DISPUTED SERVICE: Allow reimbursement \$73.84
22849	\$3702.00	\$1217.23	N/A	N/A	25%	\$1217.23 - 324.49 = 892.74 overpaid	DISPUTED SERVICE: No reimbursement recommended.

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