INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 24, 2014

Dear [Provider Name],

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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

[Chief Coding Reviewer]

cc: [Claims Administrator]
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

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 dissatisfied with reimbursement of codes 20936-59, 22830-59, 63047, 63048, 22612-RT, 22612-LT, 22852, 22849, 95861, 95937, and 95920
- The Claims Administrator allowed reimbursement of $8,039.79 for service codes 63048, 63047, 22612-RT, and 22612-LT and denied reimbursement for service codes 95920-26, 22849, 22852, 22830 Modifier 59, 20936 Modifier 59, 95937 Modifier 26 and 95861 Modifier 26.
- The Claims Administrator denied reimbursement for the following reasons: CPT codes 22849, 22852, 22830 Modifier 59 and 20936 Modifier 59: “Service is only reimbursed on an inpatient basis”. CPT codes 95937-26 and 95861-26: “The documentation does not support Service/Procedure/CPT/HCPCS billed” And “The report/documentation does not indicate that the service was performed”. CPT codes 95920-26: “The charge for this procedure was not paid since the value of this procedure is included within the value of another procedure performed. Use code 95920 in addition to the evoked potential study performed 92280, 92585, or 95925”
  - CPT 63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
  - CPT 63048 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment,
cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)
  o CPT 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
  o CPT 20936 - Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure).
  o CPT 22830 – Exploration of spinal fusion
  o CPT 22849 – Reinsertion of spinal fixation device
  o CPT 22852 – Removal of posterior segmental instrumentation
  o CPT 95861 – Needle electromyography; 2 extremities with or without related paraspinal areas
  o CPT 95937 – Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method
  o CPT 95920 – Intraoperative neurophysiology testing, per hour (List separately in addition to code for primary procedure) - Deleted 01/01/2013
  • Modifier 59 – “Distinct Procedural Service” Modifier 26 – “Professional component”
  • Authorization was obtained 12/20/2012, from the Claims Administrator. In-patient billing codes are not allowed to be billed at an Ambulatory Surgery Center, as regulations state. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to a posterior bilateral spinal fusion in the amount of $244,441.94.
  • Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and Proposed Payment Status Indicators such as:
    o T: "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment”.
    o S: “Significant procedure, not discounted when multiple”
    o N: “Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.”
    o C: "Inpatient procedure, not paid under OPPS. Admit patient and bill as inpatient."
  • The codes in question are assigned the following status indicators:
    o CPT codes 22612, 63048 and 63047 are assigned the “T” indicator.
    o CPT codes 95861 and 95937 are assigned the “S” indicator.
    o CPT codes 22849, 22852, 22830 and 20936 are assigned the "C" status indicator.
    o CPT code 95920 was deleted 01/01/2013 and is not assigned a status indicator.
  • This decision was based on OMFS Outpatient Hospital Fee Schedule.
    o CPT codes 22849, 22852 22830 and 20936 are not reimbursable at an Ambulatory Surgery Center. “Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, referenced in Section 9789.31(a), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The preauthorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.” The
authorization submitted did not verify that a pre-negotiated fee arrangement had
been obtained for the procedure to occur at a surgery center.

- CPT code 95920 is required to be billed in addition to the evoked potential study
  performed, 92280, 92585, or 95925. The codes 92280, 92585 or 95925 were not a
  part of this claim and as such, code 95920-26 is not reimbursable as a stand-alone
  code.

- CPT Codes 63048, 63047, 22612-RT, and 22612-LT were reimbursed $8,039.79
  by the Claim Administrator, which is the OMFS Allowed Amount.

- CPT codes 95937 and 95861 were denied by the Claim Administrator as the
  documentation does not support Service/Procedure/CPT/HCPCS billed. Under
  CMS, all services necessary to complete a procedure based upon standard
  medical/surgical practice are included in the procedure. Many procedures that are
  typically necessary to complete a more comprehensive procedure have been
  assigned independent HCPCS/CPT codes because they may be performed
  independently in other settings. The service described by HCPCS/CPT code
  95937 and 95861 are typically included when performing the procedures
  described by surgical procedures 22612, 63047 and 63048; therefore, the payment
  for these procedures is bundled into the APC payment rate for the surgical
  service.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement is not warranted for codes
20936-59, 22830-59, 63047, 63048, 22612-RT, 22612-LT, 22852, 22849, 95861, 95937, and
95920.

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<th>Provider Billed</th>
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