INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 12, 2014

Dear [Recipient's 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 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,

[Medical Director’s Signature]

**cc:** [Additional Contact Information]
**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
  - 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 denial of codes 22612-59 & 22325-59. Provider states “They are incorrectly bundling our services.”
- Based on the NCCI edits that exist on CPT 22612, the use of Modifier -59 is inappropriate.
- Claims Administrator denied 22612-59 and indicated on the Explanation of Review “The charge was denied as the report/documentation does not indicate that the service was performed.” CPT 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed). Based on review of the operative report, a 22630 was performed - Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar. Documentation does not support 22612 and to report billed code is inappropriate as only one segment was operated on. Claims Administrator was correct to deny CPT 22612 and therefore, no reimbursement is warranted.
- Claims Administrator denied CPT 22325-59 indicating on the Explanation of Review “This item is packaged or bundled into another basic service or surgical procedure fee
performed on this date of service. Additional reimbursement disallowed.” They also indicate “The billed procedure does not meet the minimum requirements as listed in the fee schedule.” CPT 22325 - Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar. Claims Administrator reimbursed CPT 63056 for herniated disc. Documentation is without mention of fracture or dislocation and does not support code 22325. Claims Administrator was correct to deny code 22325-59 and therefore, no reimbursement is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Based on information reviewed, reimbursement of codes 22612 and 22325 is not recommended.

<table>
<thead>
<tr>
<th>Date of Service: 2/6/2014</th>
<th>Service Code</th>
<th>Service Billed</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Assist Surgeon</th>
<th>Multiple Surgery</th>
<th>Workers’ Comp Allowed Amt.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22612-59</td>
<td>$6500.00</td>
<td>$0.00</td>
<td>$6500.00</td>
<td>N/A</td>
<td>N/A</td>
<td>$0.00</td>
<td>DISPUTED SERVICE: No reimbursement recommended</td>
</tr>
<tr>
<td></td>
<td>22325-59</td>
<td>$4145.00</td>
<td>$0.00</td>
<td>$4145.00</td>
<td>N/A</td>
<td>N/A</td>
<td>$0.00</td>
<td>DISPUTED SERVICE: No reimbursement recommended</td>
</tr>
</tbody>
</table>

National Correct Coding Initiative information:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>22612</td>
<td>22630</td>
<td>Allow Modifier</td>
</tr>
</tbody>
</table>

Copy to: