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: 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 $79.91 in additional reimbursement for a total of $329.91. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $329.91 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,

[Medical Director]

cc: [Employee Name]
**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 2254-80-51 and 63076-80.

- Claims Administrator denied codes and indicated on the Explanation of Review “As stated in the guideline instructions for CPT codes 63075 and 22554 instruct the surgeon to not report the two codes together when both procedures are performed at the same site and the same level during the same session.”
- Provider billed CPT 63075, 63076 and 22554 on the CMS 1500 form received. Based on the NCCI edits that exist, coding guidelines state 63075 and 22554 are not reported together. Therefore, reimbursement of CPT 22554 is not warranted.
- Provider also billed CPT 63076 which is a List Separately in addition to code for primary procedure. Use 63076 in conjunction with 63075.
- CPT 63076 and 22554 are also not reported together per CCI edits. However, as Claims Administrator reimbursed CPT 63075, they were incorrect to deny code 63076 as they had denied 22554.
- Based on information reviewed, reimbursement of CPT 63076 is warranted.

The table below describes the pertinent claim line information.
**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code

**Date of Service:** 11/19/2013

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Provider 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>22554-80-51</td>
<td>$953.00</td>
<td>$0.00</td>
<td>$207.10</td>
<td>Yes</td>
<td>N/A</td>
<td>$0.00</td>
<td>DISPUTED SERVICE: No reimbursement recommended</td>
</tr>
<tr>
<td>63076-80</td>
<td>$255.00</td>
<td>$0.00</td>
<td>$79.91</td>
<td>Yes</td>
<td>N/A</td>
<td>$79.91</td>
<td>DISPUTED SERVICE: Allow reimbursement $79.91</td>
</tr>
</tbody>
</table>

**National Correct Coding Initiative information:**

<table>
<thead>
<tr>
<th>File</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Version Number: 19.3 10/1/2013-12/31/2013</td>
<td>22554</td>
<td>63076</td>
<td>Allow Modifier</td>
</tr>
<tr>
<td>Physician Version Number: 19.3 10/1/2013-12/31/2013</td>
<td>63075</td>
<td>22554</td>
<td>Allow Modifier</td>
</tr>
</tbody>
</table>

Copy to:

[Redacted]

Copy to:

[Redacted]