

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Final Determination Reversed

10/17/2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB 13-0000488	Date of Injury:	11/03/2010
Claim Number:	[Redacted]	Application Received:	09/16/2013
Claims Administrator:	[Redacted]		
Date(s) of service:	04/25/2013 – 04/25/2013		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63081, 22845, 20936, 22851, 22851-59, 22851-59, 63082, 63082, 22554, 63082-59, 22585, 22585-59, 22554, 95940, L8966 (L8699) 69990, 95861, 95925, 95926, 95928 & 95929		

Dear [Redacted]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/12/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$8,450.79 for a total of \$8,785.79.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed - The following evidence was used to support the decision:

- 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
- Other: OMFS, Title 8 §9789.32.

ANALYSIS AND FINDINGS:

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Code 63081, 22845, 20936, 22851, 22851-59, 22851-59, 63082, 63082, 22554, 63082-59, 22585, 22585-59, 22554, 95940 & L8966 are under review as these services were denied in full for reimbursement on 4/25/2013.**
- CPT Codes 69990, 95861, 95925, 95926, 95928 & 95929 are listed on the IBR but were not included on the Provider's Request for Second Bill Review and thus, are not eligible to be reviewed during this IBR.
- Claims Administrator denied services due to: "The procedure code typically performed on an inpatient basis only."
- Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.
- CPT Code Descriptions:
 - **63081** Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
 - **22845** Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
 - **20936** Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or lamina fragments) obtained from same incision (List separately in addition to code for primary procedure)
 - **22851** Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methyl methacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)
 - **63082** Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
 - **22554** Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
 - **22585** Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)

- **95940** Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
- **L8966** Not a Valid Code – UB-04 = L8699. Will utilize **L8699** = Prosthetic Implant Not Elsewhere Classified
- Based on the review of the operative report, UB-04, EOR and Coding Guidelines for CPT Codes: 63081, 22845, 20936, 63082, 63082, 63082-59, 22585 & 22585-59, it was found that these codes have status indicators of “C.”
 - Title 8, California Code of Regulations, Chapter 4.5, Division of Workers’ Compensation, Subchapter 1, Administrative Director-Administrative Rules, Article 5.3 Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers Services on or after January 1, 2004 §9789.32. (e) Applicability, 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 pre-authorization 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 documentation provided includes an authorization dated 4/1/2013 for the following: 1) “Anterior Cervical Decompression and Fusion at the Levels of C4-C5, C5-C6 and C6 –C7 between 2/8/2013 and 4/24/2013.” 2) 30 Days trial of Transcutaneous Electrical Nerve Stimulator (TENS) between 2/13/13 and 5/31/2013.” And 3) Chiropractic Physiotherapy visits (4 months post-operative) between 2/13/2013 and 9/25/2013.
- Based on §9789.32. (e) for in-patient services codes 63081, 22845, 20936, 63082, 63082, 63082-59, 22585 & 22585-59 the following cannot be found on the 4/1/2013 authorization:
 - 1) Authorization of inpatient surgical services.
 - 2) Pre-negotiated fee arrangement
- Since the proper authorization, pursuant to §9789.32. (e), for in-patient CPT codes 63081 22845, 20936, 63082, 63082, 63082-59, 22585 & 22585-59 cannot be found in the documentation provided, reimbursement for these services is not recommended.
- CPT Codes 22851, 22851-59, 22851-59, 22554, & 22554 have status indicators of “T.” §9789.32. (1) Applicability, The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.
- CPT Code L8699. Has a Status Indicator of “N” there is no separate APC payment for L8699. Reimbursement is not warranted for L8699.
- Based on §9789.32. (1) and the authorization dated 4/1/2013 for CPT Codes 22851, 22851-59, 22851-59, 22554, and 22554, these services are separately reimbursable and are subjected to the multiple procedure rule.
- Reimbursement is warranted and recommended for CPT Codes 22851, 22851-59, 22851-59, 22554, and 22554.
 - 22851 = ADJ CF 80.78 x APC 32.3471 x ASC Multiplier 0.82 x MPR 50% = \$1,077.03 per

- 22554 = ADJ CF 80.78 x APC 52.7056 x ASC Multiplier 0.82 = \$3,509.79 /2 MPR = \$1,754.89
- A Correct Coding indicator of “1” was found for CPT Code 95940. This code is a Colum 2 code and is considered standard practice with CPT Code 22554 when a modifier is not applied. No Modifier was applied to CPT 95861. Reimbursement is not indicated for CPT 95940
- The table below describes the pertinent claim line information.
- **DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement warranted for the CPT codes 22851, 22851 59, 22851 59, 22554 and 22554.**

Service Code	Provider Billed	Plan Allowed	Dispute Amount	UNITS	Workers' Comp Allowed Amount	Notes
<i>Date of Service – 4/25/2013</i>						
<i>Ambulatory Surgery Center Services</i>						
63081	\$54,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
22845	\$54,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
20936-59	\$54,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
22851	\$54,000.00	\$ 0.00	\$1,743.21	1	\$1,071.33	Refer to Analysis
22851-59	\$54,000.00	\$ 0.00	\$1,743.21	1	\$1,071.33	Refer to Analysis
22851.59	\$54,000.00	\$ 0.00	\$1,743.21	1	\$1,071.33	Refer to Analysis
63082	\$22,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
63082	\$22,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
22554	\$22,000.00	\$ 0.00	\$1,743.21	1	\$3,491.20	Refer to Analysis
63082-59	\$22,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
22585	\$22,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
22585-59	\$22,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
22554	\$22,000.00	\$ 0.00	\$1,743.21	1	\$1,45.60	Refer to Analysis
95940	\$7,200.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
L8966 (L8699)	\$7,000.00	\$ 0.00	\$1,743.21	1	\$0.00	Refer to Analysis
69990	N/A	N/A	N/A	N/A	N/A	Refer to Analysis
95861	N/A	N/A	N/A	N/A	N/A	Refer to Analysis

95925	N/A	N/A	N/A	N/A	N/A	Refer to Analysis
95926	N/A	N/A	N/A	N/A	N/A	Refer to Analysis
95928	N/A	N/A	N/A	N/A	N/A	Refer to Analysis
95929	N/A	N/A	N/A	N/A	N/A	Refer to Analysis
		TOTAL	\$26,148.18	TOTAL	\$8,450.79	

Determination: Reversed

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (\$335.00) and the OMFS amount for CPT 22851, 22851-59, 22851-59 & 22554 (**\$8,450.79**) for a total of **\$8,785.79**.

The Claims Administrator is required to reimburse the provider **\$8,785.79** within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

[Redacted Signature]

Copy to:

[Redacted Copy Recipients]

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[Redacted Copy Recipients]