

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

5/2/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000606	Date of Injury:	8/6/2010
Claim Number:	[REDACTED]	Application Received:	10/15/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	2/19/2013 – 2/19/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22110, 22110 Modifier 59, 22116, 22116 Modifier 59, 76001 and 64830 Modifier 20		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/26/2013, 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 \$1,252.72, for a total of \$1,587.72.**

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
- Official Medical Fee Schedule or negotiated contract: OMFS
- Other: OMFS Information and Instructions, Evaluation and Management guidelines

Supporting Analysis:

The dispute regards the denial of the multiple surgical procedures (22110, 22100 Modifier 59, 22116, 22116 Modifier 59, 76001 and 64830 Modifier 20) performed on 2/19/2013. The Claims Administrator denied the procedure codes 22110, 22110 Modifier 59, 22116 and 22116 Modifier 59 with the explanation "The charge was denied as the report/documentation does not indicate that the service was performed." The Claims Administrator denied the procedure code 76001 with the explanation "No separate payment was made because the value of the service is included within the value of another service performed on the same day." The Claims Administrator denied the procedure code 64830 with the explanation "The charge was denied as the report/documentation does not indicate that the service was performed. Code is to be reported with nerve repair codes, none was rendered."

The Provider billed the following services for date of service 2/19/2013:

CPT 22110 – Partial excision of vertebral body for intrinsic bony lesion without decompression of spinal cord or nerve root(s) single vertebral segment; cervical

CPT 22116 – Osteotomy of spine, posterior of posterolateral approach, one vertebral segment; each additional vertebral segment (list separately in addition to primary procedure)

CPT 76001 – Fluoroscopy, physician time more than one hour, assisting a non-radiologic physician (e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)

CPT 64830 – Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair

CPT 63075 – Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace

CPT 22554 – Arthrodesis, anterior interbody technique; including minimal diskectomy to prepare interspace (other than for decompression); cervical below C2

CPT 22851 – Application of prosthetic device (e.g., metal cages, methylmethacrylate) to vertebral defect or interspace

CPT 22855 – Removal of anterior instrumentation

CPT 22849 – Reinsertion of spinal fixation device

CPT 22845 – Anterior instrumentation: 2 to3 vertebral segments

CPT 63076 – Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace

CPT 22585 – Arthrodesis, anterior interbody technique; including minimal diskectomy to prepare interspace (other than for decompression); each additional interspace (list separately in addition to code for primary procedure)

Modifier 59 – Distinct procedural service

The billed osteotomy procedure codes 22110 and 22116 describe a removal of a portion of vertebral segments. The operative report documented an anterior osteophyctomy at C5, superior and inferior parts of vertebral bodies of C6 and C7. The osteotomy procedure codes 22110 and 22116 are 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 "Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace." The description of CPT 63076 is "Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace." The Provider billed and was reimbursed for procedure codes 63075 and 63076.

The billed procedure code 76001 was denied by the Claims Administrator with the explanation "Included in another billed procedure." The coding for physician services in the OMFS is based the procedure codes, descriptors, and modifiers of the American Medical Association's Physicians'

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 Fluoroscopy and Operative report indicated the Fluoroscopy with C-arm was used for approximately 3.0 hours for surgical guidance. Additional reimbursement is warranted for the billed procedure code 76001 based on procedure code 76000 times 3 units.

The disputed procedure code 64830 is a Microdissection and/or microrepair of nerve and is listed in addition to a nerve repair code. The CPT 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. 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 additional reimbursement of \$1,252.72 is warranted per the Official Medical Fee Schedule code 76001 and 64830. There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 22110, 22110 Modifier 59, 22116 and 22116 Modifier 59.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
22110		1	\$214.39	\$0.00	\$0.00	\$0.00	OMFS
22110	59	1	\$214.39	\$0.00	\$0.00	\$0.00	OMFS
22116		1	\$261.63	\$0.00	\$0.00	\$0.00	OMFS
22116	59	1	\$261.63	\$0.00	\$0.00	\$0.00	OMFS
76001		3	\$1,729.00	\$228.00	\$0.00	\$228.00	OMFS
64830	20	1	\$1,024.72	\$1,024.72	\$0.00	\$1,024.72	OMFS

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 code 76001 and 64830 Modifier 20 (\$1,252.72) for a total of \$1,587.72.

The Claims Administrator is required to reimburse the provider \$1,587.72 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], RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]