

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

10/2/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000697	Date of Injury:	08/06/2010
Claim Number:	[REDACTED]	Application Received:	11/04/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/19/2013 – 02/19/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22110 -80; 22116 -80; 76001 -80; 64830 -80; 22110 -59,-80; 22855 -80; & 22116 -59,-80		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/28/14, 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 \$250.54 for a total of \$585.54.**

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
- Other: AMA CPT 1997

Supporting Analysis:

Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.

The dispute regards the denial of Assistant Surgeon services performed on 02/19/2013. The Claims Administrator denied the services based on various denial codes for each procedure; CPT service codes and the reasons for denial is as follows:

Disputed Codes:

- A.** 22110 -80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No separate payment was made because the value of the service is included within the value of another service performed on the same day.
- B.** 22116 -80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No additional reimbursement allowed after review of appeal/reconsideration. reimbursement allowed after review of appeal/reconsideration.
- C.** 76001 -80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No additional reimbursement allowed after review of appeal/reconsideration.
- D.** 64830, -80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No additional reimbursement allowed after review of appeal/reconsideration.
- E.** 22110, -59,-80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No additional reimbursement allowed after review of appeal/reconsideration
- F.** 22855 -80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No additional reimbursement allowed after review of appeal/reconsideration.
- G.** 22116 -59, -80: 1) Included in Another Billed Procedure. 2) The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to scheduled allowance. 3) No additional reimbursement allowed after review of appeal/reconsideration

For purposes of this discussion, the service codes in question, service indicators and supportive service codes will be defined according to The American Medical Association Current Procedural Terminology Code Book, 1997.

- **CPT 22110:** Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical
- **CPT 22116:** Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; each additional vertebral segment (List separately in addition to primary procedure)
- **CPT 76000:** Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy).
- **CPT 64830:** Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair)
- **CPT 22855:** Removal of anterior instrumentation
- **CPT 63075:** Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace
- **CPT 63076:** Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
- **Modifier -80:** Assistant Surgeon
- **Modifier -59:** Distinct Procedural Service.

It is acknowledged that there is not a contractual agreement between the Provider and the Claims Administrator; the OMFS guidelines Pursuant to Labor Code section 4603.5 and 5307.1, will be utilized for this IBR.

Regarding **Disputed Code 22110 - 59**, listed as “**A**” above, the documentation provided identifies this service at “C6” and an “anterior lower osteophyctomy” was performed. In addition to this service, at “C5/6” procedure 63075: Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, and procedure 63076: Add – on code, each additional, at “C6/7,” were also performed. It appears that the Claims Administrator reimbursed for this osteophyctomy procedure with the submitted CPT Codes 63075 and 63076. Since the Provider was reimbursed for the osteophyctomy with CPT 63075 and 63076, additional reimbursement is not recommended for CPT Code 21110-59.

Disputed Code “B,” CPT Code 22116, the documentation identifies this service at “C7” and an “anterior osteophyctomy” was performed. In addition to this service, at “C5/6” procedure 63075: Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, and procedure 63076: Add – on code, each additional, at “C6/7,” were also performed. It appears that the Claims Administrator reimbursed for this osteophyctomy procedure with the submitted CPT Codes 63075 and 63076. Since the Provider was reimbursed for the osteophyctomy with CPT 63075 and 63076, additional reimbursement is not recommended for CPT Code 22116.

Disputed Code “C,” CPT 76000, the documentation provided indicated this service was utilized throughout the procedure. Therefore, reimbursement is warranted and recommended for CPT

76000. CPT 76000 is a “BR” code. As such, per the OMFS, a comparable CPT Code may be utilized for payment. For reimbursement calculations, the comparable CPT code is 76001; this code will be the basis for payment on the fluoroscopy service.

Disputed Code “D,” CPT 64830, the Provider documents the use of Microscope for decompression and neurolysis. Procedure performed with primary procedure 22554, Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2. Based on the documentation and guidelines for this service, reimbursement is warranted and recommended at 50% of the primary procedure, 22554.

Disputed Code “E,” CPT 22110, -59,-80, documentation on the first page of the supplied Operative Report states “lower osteophylectomy” at C6. In addition to this service, at “C5/6” procedure 63075: Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, and procedure 63076: Add – on code, each additional, at “C6/7,” were also performed. It appears that the Claims Administrator reimbursed for this osteophylectomy procedure with the submitted CPT Codes 63075 and 63076. Since the Provider was reimbursed for the osteophylectomy with CPT 63075 and 63076, additional reimbursement is not recommended for CPT Code 21110-59, -80.

Disputed Code “F,” CPT 22855 -80 was mutually exclusive to CPT Code 22554 from 1997 through 1996. The coding construct during this period would not code these CPT codes separately. Based on the 1997 coding guidelines, reimbursement is not recommended for CT 22855 -80.

Disputed Code “G,” CPT 22116, -59,-80, documentation on the first page of the supplied Operative Report states “lower osteophylectomy” at C7. In addition to this service, add – on code, 63076 at “C6/7,” was also performed. It appears that the Claims Administrator reimbursed for this osteophylectomy procedure with the submitted CPT add-on code 63076. Since the Provider was reimbursed for the osteophylectomy with CPT 63076, additional reimbursement is not recommended for CPT Code 22116, -59,-80.

The additional reimbursement of **\$250.54** for Official Medical Fee Schedule codes 76001 -80 and 64830 is warranted. 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 Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
22110	80		1	\$42.88	\$0.00	\$0.00	\$0.00	OMFS
22116	80		1	\$52.33	\$0.00	\$0.00	\$0.00	OMFS
76000	(76001)	80	1	\$345.89	\$45.60	\$0.00	\$45.60	OMFS
64830	20	80	1	\$228.20	\$204.94	\$0.00	\$204.94	OMFS
22110	59	80	1	\$42.88	\$0.00	\$0.00	\$0.00	OMFS
22855	80			\$357.56	0.00	\$0.00	\$0.00	OMFS
22116	59	80		\$52.33	0.00	\$0.00	\$0.00	OMFS
			TOTAL	\$1,122.07		TOTAL	\$250.54	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 -80 and 64830 -80 (**\$250.54**) for a total of **\$585.54**.

The Claims Administrator is required to reimburse the provider \$585.54 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,

██████████, RHIT
Chief Coding Reviewer

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