

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Reversed**

5/1/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB13-0000705	Date of Injury:	7/3/1999
Claim Number:	[REDACTED]	Application Received:	11/6/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/14/2013 – 5/14/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63091 Modifier 62		

Dear [REDACTED]

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/4/2013, 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 \$536.00, for a total of \$871.00.**

**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 Surgery General Information and Ground Rules

**Supporting Analysis:**

The dispute regards the payment amount for a surgical procedure (63091 Modifier 62). The Provider billed the surgical procedure codes 63090 Modifier 62 and 63091(3 units) Modifier 62. The Claims Administrator reimbursed two units of 63091 Modifier 62 with the explanation "Recommended allowance made for two/co-surgeon. Charges denied/reduced because procedure/service was partially or fully furnished by another provider. Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description."

CPT 63090 – Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar or sacral; single segment.

CPT 63091 – Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar or sacral; each additional segment.

Modifier 62 - Two surgeons

The procedure codes 63090 and 63091 describe a corpectomy procedure performed on a vertebral segment. The codes are reported per vertebral segment. The operative report documented a multi-level partial vertebrectomy including decompression, and complete discectomy: L3-4; L4-5; and L5-S1. The partial vertebrectomies were performed on the four vertebral segments: L3, L4, L5 and S1. Reimbursement is warranted for the billed procedure code 63091 times 3 units.

Per the Official Medical Fee Schedule Surgery General Information and Ground Rules 14 (d), two surgeons: under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the payer is aware of the fee distribution according to medical ethics. The total value shall be increased by 25% in lieu of the assistant's charge. Each physician shall indicate the percentage of total payment agreed upon when submitting claim.

The operative report indicated the co-surgeons both agreed to a portion of the total surgical fees of 50% to each co-surgeon. Per the explanation of review (EOR), the Provider was reimbursed for two units of the billed procedure code 63091 based on the co-surgeon formula and agreed upon percentage of 50%. Additional reimbursement for the third unit is warranted for the billed procedure code 63091 Modifier 62.

The additional reimbursement of \$536.00 is warranted per the Official Medical Fee Schedule code 63091 Modifier 62.

