

Supporting Analysis:

The dispute regards the denial of a surgical procedure (64830) and radiological procedures (72100 and 72148 Modifier 26). The Claims Administrator denied the billed procedure code 64830 with the explanation "Based on a clinical review, this service/procedure was denied as inclusive in another service/procedure on this date." The billed procedure codes 72100 and 72148 Modifier 26 were denied by the Claims Administrator with the following explanation "Based on clinical review, payment for this service has been denied as medical documentation does not support the services rendered."

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

CPT 72100 – Radiological examination, spine, lumbosacral; anteroposterior and lateral

CPT 72148 – Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material

Modifier 20 – Microsurgery

Modifier 26 – Professional component

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 as "Microdissection was needed for more than simple magnification. It was necessary to treat the pathology by performing a neurolysis of the L5 and S1 nerve root." 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 63047.

The second and third disputed codes are CPT 72100 (2 units) and 72148 Modifier 26 performed on date of service 4/9/2013. Per OMFS Radiology and Nuclear Medicine General Information and Ground Rules, certain procedures are a combination of both a physician (professional) and a technical component. The professional component represents the value of the professional radiological services of the physician. This includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination and consultation with the referring physician. Based on the Operative Report, the Provider documented the following to support the billing of the radiology services "The first lateral lumbar x-ray was taken to confirm the appropriate incision site. A second lumbar radiograph was taken to confirm the appropriate levels. All the x-rays were interpreted by both of the surgeons for safety reasons." The Operative Report indicated an "Intra-operative review of Lumbar MRI (CPT 72148 Modifier 26). The confirmation x-rays were inclusive to the primary procedure performed. The Provider did not submit separate reports to support the services (72100 and 72148 Modifier 26) were separate from the primary procedure; therefore, reimbursement is not recommended.

The additional reimbursement of \$1,279.08 is warranted per the Official Medical Fee Schedule code 64830. There is no reimbursement warranted per the Official Medical Fee Schedule codes 72100 and 72148 Modifier 26.

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
64830	20	1	\$1,279.08	\$1,279.08	\$0.00	\$1,279.08	OMFS
72100		2	\$104.50	\$0.00	\$0.00	\$0.00	OMFS
72148	26	1	\$121.60	\$0.00	\$0.00	\$0.00	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 64830 Modifier 20 (\$1,279.08) for a total of \$1,614.08.

The Claims Administrator is required to reimburse the provider \$1,614.08 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

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