

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 12, 2014

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

IBR Case Number:	CB14-0001022	Date of Injury:	8/2/2001
Claim Number:	[REDACTED]	Application Received:	7/18/2014
Claims Administrator:	[REDACTED]	Assignment Date:	8/26/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64999		

Dear [REDACTED]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$250.00 for the review cost and \$3065.54 in additional reimbursement for a total of \$3315.54. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3315.54 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[REDACTED]
Medical Director

cc: [REDACTED]
[REDACTED]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- Negotiated contracted rates: PPO Contract Discount 5%
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

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

- **ISSUE IN DISPUTE:** Provider is dissatisfied with denial of CPT 64999 unlisted code.
- Claims Administrator denied code 64999 and indicated on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day (64999).” Claims Administrator denied CPT 64999 based on payment having been made on CPT 64999. Provider only billed CPT 64999 one time per CMS 1500 form received.
- CPT 64999 is unlisted on the OMFS. Provider’s appeal letter dated May 13, 2014 states a comparable code of 64999 to 63090. 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.
- Based on review of the operative report submitted, an anterior arthrodesis including discectomy was performed (22558 billed). Documentation further states “The disk was then removed in the entirety including cartilage and placed on the posterior longitudinal ligament which was partially taken down to decompress the cauda equine and exiting nerve roots” which provider billed CPT 64999.

- Pursuant Title 8 California Code of Regulations §9789.11 (a)(1) General Information and Instructions: In some instances, the values of BR(By Reports) procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.
- CPT 63090 closely matches procedure billed as 64999 and Claims Administrator was incorrect to deny code. Therefore, reimbursement of 64999 based on OMFS 63090 is warranted. A PPO Contract discount of 5% shall be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code 64999 is warranted.

Date of Service: 2/24/2014							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64999	\$4500.00	\$0.00	\$3226.88	N/A	N/A	\$3226.88	DISPUTED SERVICE: Allow reimbursement \$3065.54 per PPO Contract

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