

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 5, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001050	<b>Date of Injury:</b>	08/15/2011
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	07/28/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	09/02/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	63090, 22558-62, 22851, 22851-59, 22845, 72100x45 and 72148 all with Modifier -22		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement..] A detailed explanation of the decision is provided later in this letter.**

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:
- National Correct Coding Initiatives
- Other: Official Medical Fee Schedule Physician Services

## 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 reimbursement of codes 63090, 22558, 22851, 22851, 22845, 72100x45 and 72148 all with Modifier -22. Provider states “The Claims Administrator did not pay in accordance with the Official Medical Fee Schedule and failed to apply the Modifier 22 to all the CPT codes that were billed. In addition, they only paid for one X-ray when they should have paid for 45 X-rays because a total of 45 X-rays were taken for this procedure.”
- Claims Administrator reimbursed \$7449.61 indicating on the Explanation of Review (EOR) “Reimbursement is based on the Physician Fee Schedule when a professional service was performed in the facility setting.”
- Review of the EOR submitted shows that reimbursement was indeed based on the Physician Fee Schedule. All calculations of codes billed were accurate according the OMFS and are listed in the table below.
- The Provider’s Operative Report was reviewed by Maximus Chief Medical Director who states “There is only an operative report and a separate checklist for -22. I find the -22 modifier unfavorable in this case. There is no mention of additional time or complexity within the context of the official operative report. The checklist marks off generic options for using the -22 modifier. It is signed but not a dated signature. The items checked are not mentioned within the context of the official operative report and cannot be verified for medical necessity.” Based on the Medical Director’s review, additional reimbursement for Modifier -22 is not warranted. CPT 72100 x 45 units was also billed. Pursuant to **CMS’ Medically Unlikely Edits** which states “An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report

under most circumstances for a single beneficiary on a single date of service.” **CPT code 72100 has a Practitioner Service MUE Value of 1** and therefore, no further reimbursement for additional units of 72100 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of disputed codes is not warranted.**

<b>Date of Service: 4/14/2014</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
63090-22	\$4033.60	\$3226.88	\$806.72	N/A	100%	\$3226.88	<b>DISPUTED SERVICE:</b> No reimbursement recommended
22558 -62	\$3214.83	\$1578.94	\$28.48	Co-Surgeon	25% increase and split in half	\$1578.94	<b>DISPUTED SERVICE:</b> No reimbursement recommended
22851-22	\$824.04	\$659.60	\$164.44	N/A	Add-on code 100%	\$659.60	<b>DISPUTED SERVICE:</b> No reimbursement recommended
22851-99-22-59	\$824.04	\$626.62	\$197.42	N/A	PPO Discount 5%	\$626.62	<b>DISPUTED SERVICE:</b> Claims Admin states a Contract Agreement discount 5%
22845-22	\$1479.19	\$1183.35	\$295.84	N/A	Add-on 100%	\$1183.35	<b>DISPUTED SERVICE:</b> No reimbursement recommended
72100 x45 - 22	\$3432.60	\$61.02	\$3371.58	Only 1 unit allowed	100%	\$61.02	<b>DISPUTED SERVICE:</b> No reimbursement recommended
72148 -99-26-22	\$148.95	\$113.20	\$35.75	N/A	PPO Discount 5%	\$113.20	<b>DISPUTED SERVICE:</b> Claims Admin states a Contract Agreement discount 5%

Copy to:

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

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]