

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 24, 2014

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

<b>IBR Case Number:</b>	CB14-0001063	<b>Date of Injury:</b>	08/15/2011
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	07/31/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	09/08/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	22612, 22842, 22851, 64550, 64550, 72100, &72148		

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]  
[REDACTED]

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
- National Correct Coding Initiatives
- Other: OMFS 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 denial of codes 22612, 22842, 22851, 64550, 64550, 72100 and 72148
- Claims Administrator reimbursed \$2501.74 and indicated on the Explanation of Review “Services are not payable as documentation does not support the services rendered.”
- Claims Administrator sent a second payment of \$4445.62 which included codes 22612, 72100 and 72148 and therefore no additional reimbursement is owed for these codes.
- Based on review of the operative report, Claims Administrator was correct to deny codes 22842, 22851, 64550 and 64550 as documentation is lacking to support any of these codes billed. No reimbursement if recommended for these codes.
- Provider’s Operative Report was reviewed by our Chief Medical Director. Director’s conclusion states “This case does not meet the medical necessity of adding a -22 modifier. Although the op report makes reference to increased surgical time and there is a checklist of indications for prolonged surgery, there is no supportive documentation of what procedures were extended to account for the additional payment above and beyond the upper limits of normal for this procedure. This should be documented in the operative report and identified. There are no anesthesia records to support the timing.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, no reimbursement of codes 22842-22, 22851-22, 64550-22-59, 64550-22-59 and 64550-22-59 is warranted.**

Date of Service: 4/15/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22842-22	\$ 5083.00	\$ 0.00	\$5083.00	Allow	N/A	\$ 0.00	<b>DISPUTED SERVICE: No reimbursement recommended</b>
22851-22	\$ 2490.00	\$ 0.00	\$2490.00	Allow	N/A	\$ 0.00	<b>DISPUTED SERVICE: No reimbursement recommended</b>
22851-22-59	\$ 2490.00	\$ 0.00	\$2490.00	Allow	N/A	\$ 0.00	<b>DISPUTED SERVICE: No reimbursement recommended</b>
64550-22-59	\$129.00	\$ 0.00	\$129.00	Do Not Allow	N/A	\$ 0.00	<b>DISPUTED SERVICE: No reimbursement recommended</b>
64550-22-59	\$129.00	\$ 0.00	\$129.00	Do Not Allow	N/A	\$ 0.00	<b>DISPUTED SERVICE: No reimbursement recommended</b>

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