

**MAXIMUS FEDERAL SERVICES, INC.**

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



---

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 15, 2014

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

<b>IBR Case Number:</b>	CB14-0001152	<b>Date of Injury:</b>	06/12/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	08/18/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	09/22/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	22899		

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: 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 CPT code 22899
- Claims Administrator denied code and indicated on the Explanation of Review “The value of this procedure is included in the value of another procedure performed on this date.”
- Provider disputes this denial explanation on the IBR application stating “Incorrectly bundling CPT code 22899”
- CPT 22899 - Unlisted procedure, spine; and has a status code ‘C’ – Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- Pursuant to Title 8 General Information and Instructions (8 CCR §9789.11 (a) (1)), Procedures without unit values (“By Report”) – Unit values are not shown for some procedures listed in the Schedule. Fees for such procedures need to be justified by report, although a detailed clinical record is not necessary.
- By Report: Procedures coded BR (By Report) are services which are unusual or variable. An unlisted service or one that is rarely provided unusual or variable may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service. Additional items which may be included are: Complexity of symptoms; final diagnosis;

pertinent physical findings; diagnostic and therapeutic procedures; concurrent problems; follow up care.

- No documentation to support the necessity of code 22899 was submitted for this review. Therefore, reimbursement of CPT 22899 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

<b>Date of Service:</b> 1/23/2014							
<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>
22899	\$7200.00	\$0.00	\$7200.00	Yes	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended

Copy to:

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

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]