

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 19, 2014

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

IBR Case Number:	CB14-0001154	Date of Injury:	01/07/2013
Claim Number:	[REDACTED]	Application Received:	08/19/2014
Claims Administrator:	[REDACTED]	Assignment Date:	09/26/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22554, 22585, 63075, 63076, 22851, 22851, 22845, 22110, 22116, 22116-59x2, 72040, 69990, 22220, and 72141		

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: PPO Contract
- National Correct Coding Initiatives
- Other: OMFS Physician Services, Chief Medical Director Review

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 procedure codes 22554, 22585, 63075, 63076, 22851, 22851, 22845, 22110, 22116, 22116-59x2, 72040, 69990, 22220 and 72141 all with Modifier 22: Unusual Procedure Services.
- Provider was reimbursed \$8882.66 and is seeking additional reimbursement of \$6188.13.
- Claims Administrator reimbursed \$8882.66 and indicated on the Explanation of Review “Any reduction is in accordance with a [REDACTED] owned contract. This reimbursement may reflect payment at rates less than the state fee schedule in accordance with your PPO access agreement with [REDACTED] or a [REDACTED] owned entity.”
- Due to no contract submitted after request by IBR, reimbursement is believed to have been correct per agreement between Provider and Claims Administrator.
- NCCI edits exist on codes 63076 and 69990 and therefore, they do not warrant reimbursement. Codes 22116 and 22110 were not authorized and do not warrant reimbursement. Code 72141 was not documented in the report and does not warrant reimbursement.
- The Operative Report was submitted to our Chief Medical Director for review of Modifier 22. Per Director’s review, “there is no separate identifiable documentation to support the use of a -22 modifier. Generally, if there was work performed above the usual, it would be reflected as very specific details and time and effort. This op note mentions time, etc. but I am not seeing the anesthesia records or other clear description to

justify payment above and beyond the usual to warrant justification of the -22. I had the opportunity to consult with a neurosurgeon as well.” Therefore, no additional reimbursement is recommended.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, no additional reimbursement of codes 22554, 22585, 63075, 63076, 22851, 22851, 22845, 22110, 22116, 22116-59x2, 72040, 69990, 22220 and 72141 is warranted.

Date of Service: 3/24/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22554 - 22	\$2588.68	\$1229.63	\$1359.05	N/A	50% +PPO reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22585-22	\$674.24	\$640.53	\$33.71	N/A	PPO reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
63075-22	\$1389.81	\$1320.32	\$69.49	N/A	50%	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
63076-22	\$499.44	\$0.00	\$499.44	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22851-22	\$824.04	\$626.62	\$197.42	N/A	PPO reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22851-22	\$824.04	\$626.62	\$197.42	N/A	PPO reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22845-22	\$1479.19	\$1124.18	\$355.01	N/A	PPO reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22110-22	\$1100.98	\$0.00	\$1100.98	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22116-22	\$283.54	\$0.00	\$283.54	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22116-22	\$283.54	\$0.00	\$283.54	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22116-22	\$283.54	\$0.00	\$283.54	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.

72040-22	\$1144.13	\$173.90	\$970.23	N/A	PPO reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
69990-22	\$215.58	\$0.00	\$215.58	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
22220-22	\$3361.23	\$3140.87	\$220.36	N/A	PPO Reduction	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.
72141-22	\$118.81	\$0.00	\$118.81	N/A	N/A	\$ 0.00	DISPUTED SERVICE: No additional reimbursement recommended.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.0 1/1/2014-3/31/2014	22554	63076	Allowed
Physician Version Number: 20.0 1/1/2014-3/31/2014	22220	69990	Not Allowed

Copy to:

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

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]