

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 22, 2015

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██████████  
██████████

IBR Case Number:	CB14-0001777	Date of Injury:	10/14/2002
Claim Number:	██████████	Application Received:	11/20/2014
Claims Administrator:	██████████		
Assigned Date:	12/24/2014		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	22830-59		

Dear ██████████

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,

Paul Manchester, MD, MPH  
Medical Director

cc: ██████████  
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## 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 Policy Manual for Medicare 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 code 22830
- Claims administrator denied code indicating on the Explanation of Review “In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: Musculoskeletal system procedure (20000-29999) has been disallowed.”
- Based on NCCI edits Revision Date (Medicare) 1/1/2014 submitted by the provider, Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59.
- Based on review of the operative report submitted, provider states he performed a C5-C6 fusion exploration. He also states he performed a plate screw removal at the same location: “C5-C6 fusion exploration and plate \_\_ screw removal”. As the NCCI edit states, Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical

field, CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area, such as the C5-C6 described by the provider's documentation.

- Based on information reviewed, documentation does not support the use of code 22830 and therefore, no reimbursement is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 22830 is not recommended.

<b>Date of Service:</b> 5/1/2014							
<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>
22830	\$5680.00	\$0.00	\$5680.00	N/A	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended.

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