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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 19, 2015

[redacted]

IBR Case Number:	CB14-0001904	Date of Injury:	09/06/2013
Claim Number:	[redacted]	Application Received:	12/09/2014
Claims Administrator:	[redacted]		
Assigned Date:	1/20/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	22521-58, 22522-58, 22522-58-59 & 72291-26		

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $1375.03 in additional reimbursement for a total of $1625.03. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1625.03 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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: [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

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 22521-58, 22522-58, 22522-58-59 and 72291-26
- Claims administrator denied codes indicating on the Explanation of Review "The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing" and "The billed procedure does not meet the minimum requirements as listed in the fee schedule". 72291-26 was denied as "Payment disallowed – unable to substantiate the billed service was rendered."
- Documentation submitted included the Provider's operative report which states vertebroplasty was performed at L3, L4 and L5 under C-arm guidance. Claims administrator changed code 22521 to 22524 which is vertebral augmentation using balloons for the procedure. Vertebroplasty was performed with needles as documented in the operative report and therefore 22521 is the appropriate code to bill. 22522 is the add-on code used with 22521 when more than one vertebral body is involved which the provider also documents as L3, L4 and L5.
- Based on information reviewed, reimbursement of 22521 and 22522 x 2 is warranted.
- Provider also documents the use of C-arm fluoroscopy during the placement of the Jamshidi needles and therefore reimbursement of 72291-26 is warranted.

The table below describes the pertinent claim line information.

- DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 22521-58, 22522-58, 22522-58-59 and 72291-26

Date of Service: 7/15/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
22521	$1675.00	$0.00	$1675.00	1	50%	$404.47	**DISPUTED SERVICE**: Allow reimbursement $404.47
22522-58	$698.00	$0.00	$698.00	1	100%	$372.87	**DISPUTED SERVICE**: Allow reimbursement $372.87
222522-58-59	$698.00	$0.00	$698.00	1	100%	$372.87	**DISPUTED SERVICE**: Allow reimbursement $372.87
72291-26	$710.00	$0.00	$710.00	2	N/A	$224.82	**DISPUTED SERVICE**: Allow reimbursement $224.82

Copy to:

[redacted]

Copy to:

[redacted]