

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 13, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000006	Date of Injury:	04/29/2014
Claim Number:	[Redacted]	Application Received:	01/02/2015
Claims Administrator:	[Redacted]		
Assigned Date:	02/10/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63081-62, 63082-62 (2 units), 22554-51-62, 22585-62, 22845-62, 22851-62 (2 units)		

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 \$195.00 for the review cost and \$1831.96 in additional reimbursement for a total of \$1886.96. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1886.96 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]  
[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
- 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 reimbursement of codes 63081-62, 63082-62 (2 units), 22554-51-62, 22585-62, 22845-62, 22851-62 (2 units) performed on 8/1/2014.
- Provider billed codes on a CMS 1500 form with billed amounts already reduced per modifier -62 rule: Per the Official Medical Fee Schedule Surgery General Information and Ground Rules 14 (d), two surgeons: under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the payer is aware of the fee distribution according to medical ethics.
- Documentation of the medical necessity for two surgeons is required for certain services identified in the Co-Surgeons (“Co Surg”) column of the National Physician Fee Schedule Relative Value File. If the surgery is billed with a “-62” modifier and the Co-Surgeons column contains an indicator of “1,” any documentation submitted with the claim should be reviewed to identify support for the need for co-surgeons. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount. If the surgery is billed with a “-62” modifier and the Co-Surgeons column contains an indicator of “2,” payment rules for two surgeons apply. The claims administrator shall base payment for

each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount.

- All surgical procedure codes have an assigned indicator of either “1” or “2.”
- The operative report indicated the co-surgeons both agreed to apportion of the total surgical fees of 50% to each co-surgeon.
- Claims administrator reduced the already reduced billed charges by another 62.5% which is incorrect reimbursement for the OMFS co-surgeon rule.
- CPT code 22554-62 is subject to the multiple procedure reduction rule and is reimbursed at 50% of allowed OMFS as it is the secondary procedure as 63081-62 is the primary procedure reimbursed at 100%. All the other codes billed are List Separately codes and reimbursed at 100% OMFS as they are not subject to multiple reduction.

The table below describes the pertinent claim line information.

- **DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes 63081-62, 63082-62 (2 units), 22554-51-62, 22585-62, 22845-62, 22851-62 (2 units) is recommended.**

Date of Service: 8/1/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Co-Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63081-62	\$1797.79	\$1123.62	\$674.17	Modifier -62	100%	\$1797.79	<b>DISPUTED SERVICE:</b> Allow reimbursement \$674.17
63082-62 x 2	\$539.18	\$336.99	\$202.19	Modifier -62	100%	\$539.18	<b>DISPUTED SERVICE:</b> Allow reimbursement \$202.18
22554-62	\$1294.34	\$404.48	\$242.69	Modifier -62	50%	\$647.17	<b>DISPUTED SERVICE:</b> Allow reimbursement \$242.69
22585-62	\$337.12	\$210.70	\$126.42	Modifier -62	100%	\$337.12	<b>DISPUTED SERVICE:</b> Allow reimbursement \$126.42
22845-62	\$739.59	\$462.24	\$277.35	Modifier -62	100%	\$739.60	<b>DISPUTED SERVICE:</b> Allow reimbursement \$227.35
22851-62 x 2	\$824.38	\$515.24	\$309.14	Modifier -62	100%	\$824.50	<b>DISPUTED SERVICE:</b> Allow reimbursement \$309.15

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