

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 7, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000769	Date of Injury:	02/19/2010
Claim Number:	[Redacted]	Application Received:	05/08/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	02/17/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22610-AS-59, 63044-AS-59, 63012-AS-59, 63047-AS-59, 63048-AS-59, and 22848-AS-59		

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 \$557.85 in additional reimbursement for a total of \$752.85. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$752.85 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
- 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 22610-AS-59, 63044-AS-59, 63012-AS-59, 63047-AS-59, 63048-AS-59, and 22848-AS-59
- Claims Administrator denied codes indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- Although pair codes exist between denied codes and codes already reimbursed, Modifier Indicator column shows ‘1’ which states if an approved modifier is appended to the column two code and documentation is submitted to support billed code, then the modifier may be overridden.
- Modifier -59 is an approved modifier to append to these codes which the Provider did.
- Documentation submitted does support billed codes.
- §9789.16.5 Surgery–Multiple Surgeries and Endoscopies: (c) When a NPP actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NPP’s services are eligible for payment as assistant-at-surgery services. Maximum fees for covered NPP assistant-at-surgery services shall be 85 percent of what a physician is paid under the Official Medical Fee Schedule-Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount for assistant-at-surgery services, the actual payment amount that NPPs receive for assistant-

