

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 8, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000771	Date of Injury:	03/31/2014
Claim Number:	[REDACTED]	Application Received:	05/12/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/31/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63081, 63082-59 X 3, 22851-59 X 3, 69990-59, and 76001-59		

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 \$3848.37 in additional reimbursement for a total of \$4043.37. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$4043.37 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 reimbursement of codes 63081, 63082-59 X 3, 22851-59 X 3, 69990-59, and 76001-59

- Provider denied codes indicating on the Explanation of Review “The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed”
- Provider billed code 69990-59 along with reimbursed billed code 22554. Per NCCI Edit of the pair code between these two states they are never to be billed together and a modifier is not allowed to override the edit. As such, reimbursement of 69990 is not warranted.
- Claims Administrator also denied code 76001-59, Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)
- Provider’s report submitted does not document 76001 and therefore, reimbursement is not warranted for 76001.
- Provider also billed 3 units of 22851-59, Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure) which is documented in the provider’s report.

- Reimbursement of 22851 x 3 is warranted.
- Provider also billed 63081, Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
- Provider's report documents "A partial corpectomy had to be carried out before we were able to remove the posterior osteophyte and decompress the spinal cord because of the very narrow disc space"
- Reimbursement of 63081 is warranted.
- Provider documents "The same happened at C4-5 as well where partial corpectomy had to be carried out as well" which supports billed code 63802, Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure) for 1 unit.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 22851 x 3 units, 63081 and 63082 is recommended.

Date of Service: 10/31/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22851	\$9420.00	\$0.00	\$9420.00	3	100%	\$1978.80	DISPUTED SERVICE: Allow reimbursement \$1978.80
63081	\$11000.00	\$0.00	\$2876.46	1	50%	\$1438.23	DISPUTED SERVICE: Allow reimbursement \$1438.23
63082	\$10500.00	\$0.00	\$1294.02	1	100%	\$431.34	DISPUTED SERVICE: Allow reimbursement \$431.34

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.3	22554	69990	No
Physician Version Number: 20.3	22554	76001	Allowed

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[REDACTED]
[REDACTED]
[REDACTED]