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## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 10, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001105	Date of Injury:	07/29/2014
Claim Number:	[REDACTED]	Application Received:	06/18/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/18/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22558-62 and 22845		

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 \$2679.42 in additional reimbursement for a total of \$2874.42. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2874.42 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: 3% PPO Discount
- 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 22558-62 and 22845
- 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. (22558-62)” and “The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service on another bill. An allowance has either not been paid or the maximum allowance for the MUE has been paid”
- Provider submitted codes 22558-62, 22845 and 22851 on a CMS 1500 form. Only code 22851 was reimbursed which is the add on code to primary procedure 22558
- Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes.

The reported primary code should be the one corresponding to the spinal region of the first procedure.

- Provider’s report documents procedure codes 22558-62 and 22845 performed on date of service 02/18/2015.
- Based on information reviewed, reimbursement of codes 22558-62 and 22845 is warranted.
- Provider billed modifier -62 for primary procedure 22558. Payment for each co-surgeon is based on the lesser of the actual charges or 62.5% of the Medicare Physician Fee Schedule (MPFS) amount.
- A 3% PPO reduction was reflected on the EOR received and shall be applied to reimbursement of codes 22558-62 and 22845.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 22558-62 and 22845**

<b>Date of Service: 02/18/2015</b>							
<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>
22558-62	\$2526.30	\$0.00	\$2526.30	Modifier -62	100%	\$1531.57	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1531.57
22845	\$1183.35	\$0.00	\$1183.35	No	100%	\$1147.85	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1147.85

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