

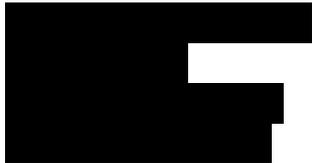
MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 31, 2016



| | | | |
|-----------------------|---|-----------------------|------------|
| IBR Case Number: | CB16-0000617 | Date of Injury: | 05/19/1999 |
| Claim Number: | [REDACTED] | Application Received: | 04/18/2016 |
| Claims Administrator: | [REDACTED] | | |
| Date(s) of service: | 01/22/2016 – 01/22/2016 | | |
| Provider Name: | [REDACTED] | | |
| Employee Name: | [REDACTED] | | |
| Disputed Codes: | 63047-62-22, 63048-62-22, and 22830-62-59 | | |

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 \$221.23 in additional reimbursement for a total of \$416.52 A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$416.52 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,

MAXIMUS

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cc:



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
- Other: OMFS Physicians Fee Schedule

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 seeking additional reimbursement for codes 63047-62-22, 63048-62-22, and 22830-62-59 performed on date of service 01/22/2016**
- Provider billed codes along with 22612 on a CMS 1500 with Place of Service '21'
- Claims Administrator denied 22830 with indication "value of service is included within the value of another service performed on the same day"
- Provider's Operative Report documents "Procedure: 2. Exploration of posterolateral fusion L2 to L5; 3. Bilateral revision laminectomy L1; 4. Bilateral revision laminectomy L2; 5. Bilateral revision laminectomy L3; 7. Bilateral posterior intertransverse fusion at L1 to L4 (CPT 22612) & (CPT 22614 x 2)"
- Pursuant Medicare NCCI Policy Chapter IV: Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59.
- Reimbursement of 22830 is not warranted.
- Page 2 of Provider's report documents co-surgeons during this procedure and they "agreed to apportion the total surgical fees 50% to each co-surgeon"

- Modifier -62 as well as modifier -22 (25% increase in service) were appended to codes 63047 and 63048.
- When submitting a claim with modifier 22, the physician should document what aspects of the procedure were above and beyond the typical.
- Page three of Operative Report documents “Additional operative time was necessary during a portion of this patient’s revision spinal procedure because of the scarring from the previous surgery. This created significant technical difficulty. Significant time was spent exposing and removing the previous posterior instrumentation and exploring the posterolateral fusion area.”
- The additional time billed due to extensive scar tissue is appropriate.
- Documentation support modifier -22 for increase service value of 25%.
- As 22612 is the main procedure, CPT 63047 is subject to multiple procedure reduction.
- 63047 has a 2016 RBRVS of \$1613.45.
- $1613.45 \times 125\% = 2016.81 / 2$ (co-surgeon) = $1008.41 / 2$ (MPPR) = $504.20 + 25\% = 630.25$
- 63048 has a 2016 RBRVS of \$305.58, and is not subject to MPPR.
- $305.58 \times 125\% = 381.98 / 2$ (co-surgeon) = $190.99 + 25\% = 238.73 \times 2$ units = 477.47.
- PPO contract not submitted for review.
- Based on calculations with increased service value, additional reimbursement is indicated for 63047 and 63048 x 2 units.
- The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes: 63047-62-22, 63048-62-22 and 22830.

| Date of Service 1/22/2016 | | | | | | | |
|---------------------------|-----------------|--------------|----------------|----------------|-------|----------------------------|--|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Units | Workers' Comp Allowed Amt. | Notes |
| 63047-62-22 | \$1413.55 | \$504.21 | \$1413.55 | Yes | 1 | \$630.25 | DISPUTED SERVICE- See analysis. |
| 63048-62-22 | \$536.82 | \$381.98 | 536.82 | Yes | 2 | \$477.47 | DISPUTED SERVICE- See analysis |
| 29830-62-59-22 | \$1079.62 | \$0.00 | \$1079.62 | N/A | 1 | \$0.00 | DISPUTED SERVICE- See analysis |

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