

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/18/2014

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IBR Case Number:	CB14-0000102	Date of Injury:	07/31/2008
Claim Number:	██████	Application Received:	01/23/2014
Claims Administrator:	████████████████████		
Date(s) of service:	10/15/2013 – 10/15/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	22830 -62,-59,-22,-51; 22855,-80,-22,-59,-51; 63090 -62,-22, 63091 -62,-22; and 63047 -62,-22		

Dear ██████████:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/03/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$1,002.38, for a total of \$1,337.38.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed - The following evidence was used to support the decision:

- 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
- Other: OMFS Surgery Information and Ground Rules, AMA, CPT 1997, Physician Review

Supporting Analysis:

The dispute regards the denial of increased procedural services performed by the Provider, Co-surgeon and Assistant Surgeon for services dated 10/15/2013. Specifically, the Provider believes the Claims Administrator did not reimburse the amount owed for Modifier -22.

For purposes of this review, the CPT codes and modifiers in question will be defined utilizing the 1997 American Medical Association Current Procedural Terminology Code book. Reimbursement explanations provided by the Claims Administrator for each CPT code and Modifier in question, will be provided as well.

The American Medical Association Current Procedural Terminology Code Book, 1997, defines the codes in question as follows:

- CPT 22830: Exploration of spinal fusion
- CPT 22855: Removal of anterior instrumentation
- CPT 63090: Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar or sacral; single segment.
 - CPT 63091: each additional segment
- CPT 63047: Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
- Modifier 22: Increased procedural services
- Modifier 51: Multiple procedures
- Modifier 59: Distinct procedural service
- Modifier 62: 2 Surgeons
- Modifier 80: Assistant Surgeon leave

The Claims Administrator provided the following reasons for reimbursement for CPT 22830 -62,-59,-22:

1. Courtesy reimbursement for failed appointment
2. Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned.
3. Charge exceeds Fee Schedule allowance
4. Charge exceeds the Workers Compensation Fee Schedule allowance
5. Modifier (22) Unusual Procedure Service

CPT 22830 -62,-59,-22, as well as other relevant procedures for this date of service, was submitted by the Provider and reviewed by the Claims Administrator initially on 11/06/2013. The Provider valued 22830 -62,-59,-22 at \$1,800.00; allowance of \$717.67 was reimbursed. A second review by the Claims Administrator on 12/16/2013 did not yield additional reimbursement or offer further clarification other than the 1- 4 reasons provided above.

CPT 22855,-80,-22,-59,-51, was submitted by the Provider and reimbursed \$357.56 out of \$448.00 by the Claims Administrator for the following reasons:

1. Assistant Surgeon is reimbursed at 20% of the listed value
2. Charge exceeds Fee Schedule allowance
3. Modifier (22) Unusual Procedure Service
4. Modifier 83 Surg Asst: Services provided by Licensed non-phys 10%

CPT 63090 -62,-22, reimbursed \$799.43 out of \$1,999.00 for the following reasons:

1. Multiple Surgery Rules allow for this procedure to be paid at 50%
2. Charge exceeds Fee Schedule allowance
3. Charge exceeds the Workers Compensation Fee Schedule
4. Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned.
5. Modifier (22) Unusual Procedure Service

63091 -62,-22, reimbursed \$535.98 out of \$670.00 for the following reasons:

1. Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned.
2. Exceeds number of authorized treatments – 5 treatments were authorized
3. Modifier (22) Unusual Procedure Service

Note: Although the Claims Administrator stated “Exceeds,” the fee was paid correctly according to billed charges and modifier -62.

63047 -62,-22, reimbursed \$1,598.85 out of \$1,999.00 for the following reasons:

1. Charge exceeds Fee Schedule allowance
2. Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned.
3. Modifier (22) Unusual Procedure Service
4. The charge exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted to the schedule allowance.

Since the dispute in all of the CPT codes in question is regarding Modifier 22 and the increased service fees charged to the Claims Administrator, the provided Operative Report was reviewed by a Medical Professional in an effort to validate the extended services performed. The Physician Reviewer stated the following regarding the extended service codes on the CPT Codes in question:

“Documentation available for review identifies 10/15/13 procedure report for exploration of anterior interbody arthrodesis L5-S1; removal of anterior interbody instrumentation L5-S1; partial vertebrectomy, excision interbody pseudoarthrosis, complete discectomy L5-S1 with anterior spinal decompression; anterior interbody arthrodesis L5-S1; anterior spinal instrumentation L5-S1; and implantation of PEEK implant in the L5-S1 interspace filled with cancellous allograft and structural tissue matrix graft. The body of the surgery report identifies a paragraph specifically noting that “a considerable amount of additional operative time was necessary during several portions of the procedure because of the tedious dissection necessary to safely explore the previous interbody fusion, excise the reasons of pseudoarthrosis including the partial vertebrectomies and explant the failed interbody cage. This resulted in a 100% increase in the actual operative time for these portions of the surgery”. Therefore, given that modifier 22 criteria “increased intensity”, “time”, and “technical difficulty of procedure” are well documented, the medical record documentation supports the use of Modifier 22.”

This supported information, as determined by the Physician Reviewer, allows for increased reimbursement under the OMFS Guidelines for Modifier 22. The OMFS fee allowance for the following CPT’s: 22830 -62,-59,-22,-51; 22855,-80,-22,-59,-51; 63090 -62,-22, 63091 -62,-22; and 63047 -62,-22 based on the IBR recommendation, should each yield a reimbursement increase of 25%.

The chart below provides a comparison of charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier(s)	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
22830	62,59,22,51	1	\$1,379.246	\$897.09	\$717.67	\$179.42	OMFS
22855	80,22,59,51	1	\$1,379.246	\$446.95	\$357.56	\$89.39	OMFS
63090	62,22	1	\$1,379.246	\$999.29	\$799.43	\$199.86	OMFS
63091	62,22	1	\$1,379.246	\$669.98	\$535.98	\$134.00	OMFS
63047	62,22	1	\$1,379.246	\$1998.56	\$1,598.85	\$399.71	OMFS
		Total	\$6896.23				

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT codes; 22830 -62,-59,-22,-51; 22855,-80,-22,-59,-22,-51; 63090 -62,-22, 63091 -62,-22; and 63047 -62,-22 (**\$1,002.38**) for a total of **\$1,337.38**.

The Claims Administrator is required to reimburse the provider \$1,337.38 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers’ Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

[REDACTED], RHIT
Chief Coding Reviewer

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[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]