

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 6, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000204	Date of Injury:	7/18/2012
Claim Number:	[REDACTED]	Application Received:	2/18/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22554, 20936		

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.

IBR Assigned: 3/17/2014

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 \$335.00 for the review cost and \$1144.64 in additional reimbursement for a total of \$1479.64. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1479.64 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,

[REDACTED]
Chief Coding Reviewer

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

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: Codes 22554 and 20936 are under review as the services were denied in full SERVICE.**
- Charges billed on CMS 1500 form; Provider seeking reimbursement for Physician Services. For this review the Operative Report was available, assessed and reviewed. It was determined that CPT Code 22554 and 20936 was indeed performed in accordance with AMA CPT 1997 guidelines.
- On 29 August, 2013, six (6) CPT codes were reviewed and processed by (Claims Administrator), Tucson. The provider is questioning the reimbursement for two (2) of the six CPT codes.
- For purposes of this review, three (3) CPT codes listed on the EOB will be presented, as these codes are directly related. American Medical Association (AMA) Current Procedural Terminology (CPT) 1997, Surgery Section Code Description:
 - CPT 20936: Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process or laminar fragments) obtained from same incision.
 - CPT 22554: Arthrodesis, anterior interbody technique; including minimal
 - CPT 63075: Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace.
 - Modifier 59: Distinct Procedural Service
- The physician's office is challenging the reimbursement on two (2) CPT Codes. The first CPT Code and the associated EOB definitions for the reimbursement are as follows:
 - **CPT Code 22554;** Amount Charged \$6,500.00; Amount Reimbursed, \$0.00

- The following reimbursement rational from the insurance company is as follows:
“We cannot review this service without necessary documentation please submit with indicated documents as soon as possible.”
- The Operative Report was available, assessed and reviewed. It was determined that CPT Code 22554 was indeed performed on 08/29/09 on Levels C5 – C6.
- Authorization dated August 12, 2013 and authorized the procedure "Anterior cervical (discectomy) and fusion C5-6 63020 & 22548.”
- The American Medical Association (AMA) Current Procedural Terminology (CPT) 1997 - Surgery Section, does not stipulate that CPT Code 22554 is paired code with any of the six CPT codes submitted for date of service 29 August, 2013.
- Based on the aforementioned guidelines and provided documentation, reimbursement is warranted for CPT 22554 physician services and reimbursement is recommended to the Provider.
- **The second CPT Code in question is 22554.**
 - **CPT Code 20936;** Amount Charged \$1,550.00; Amount Reimbursed, \$0.00
 - The following reimbursement rational from the insurance company is as follows:
“We cannot review this service without necessary documentation please submit with indicated documents as soon as possible.”
- The Operative Report was available, assessed and reviewed. It was determined that CPT Code 20936 was indeed performed on 08/29/09 on Levels C5 – C6.
- Authorization dated August 12, 2013 and authorized the procedure "Anterior cervical (discectomy) and fusion C5-6 63020 & 22548.”
- CPT 20936 and its relationship to the codes billed for this date of service do not have coding conflicts according to 1997 guidelines.
- Based on the aforementioned guidelines and provided documentation, reimbursement is warranted for CPT 20936 and reimbursement is recommended to the Provider.
- Billed procedure codes, based on weights for the procedures performed and during the same session for the Injured Worker, are as follows:
 - 22845 17.3 wt. **Primary**
 - 22554 14.1
 - 63075 14
 - 22851 5.4
 - 20936 1.7
 - 64830 “BR”
- PPO discount applied: 10%

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation presented for this review, reimbursement is warranted and recommended for CPT 22554 and CPT 20936.

Date of Service: 08/29/2013							
Physician's Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery Allowance	Workers' Comp Allowed Amt.	Notes
22554	\$6,500	\$0.00	\$1,946.97	N/A	50%	\$922.25	DISPUTED CODE: See Analysis
20936	\$1,550	\$0.00	\$234.75	N/A	100%	\$222.39	DISPUTED CODE: See Analysis
22845	N/A	N/A	N/A	N/A	N/A	N/A	NOT IN DISPUTE
63075	N/A	N/A	N/A	N/A	N/A	N/A	NOT IN DISPUTE
22851	N/A	N/A	N/A	N/A	N/A	N/A	NOT IN DISPUTE
64830	N/A	N/A	N/A	N/A	N/A	N/A	NOT IN DISPUTE

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