

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/17/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000210	Date of Injury:	08/15/2001
Claim Number:	[REDACTED]	Application Received:	02/18/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/04/2013 – 10/04/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63047 22, 63048 22 x 2 (units)		

Dear [REDACTED] .:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/14/2014, 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 \$1,204.00, for a total of \$1,539.00.**

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

Supporting Analysis:

The dispute regards the denial of full services performed by the Provider and a Co-surgeon for services performed on 10/04/2013. The Provider believes the Claims Administrator partially reimbursed the full amount owed for these services and is seeking the full amount of the initial claim.

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.

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

- **CPT 63047 -62, -22:** 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
- **CPT 63048 -62, -22 X2:** 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; each additional segment, cervical, thoracic, or lumbar
- **Modifier 62:** 2 Surgeons
- **Modifier 22:** Increased procedural services

The Claims Administrator provided the following reasons for reimbursement for CPT 63047 -62, -22:

1. Charge exceeds fee schedule allowance.
2. Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned.
3. Modifier 22, Unusual Procedure.
4. The Charge Exceeds the Official Medical Fee schedule allowance. The charge has been adjusted to the schedule allowance.
5. Workers Compensation Jurisdictional Fee Schedule Adjustment.

CPT 63047 -62, -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 10/22/2013. The Provider valued CPT 63047 -62, -22 at \$1999.00. An allowance of \$1598.85 was reimbursed to the Physician by the Claims Administrator. A second review by the Claims Administrator on 01/10/2014 did not yield additional reimbursement or offer further clarification other than the 1 - 5 reasons provided above.

The Official Medical Fee Schedule Surgery General Information and Ground Rules 14 (d) states: "Two surgeons: under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the payer is aware

of the fee distribution according to medical ethics. The total value shall be increased by 25% in lieu of the assistant's charge. Each physician shall indicate the percentage of total payment agreed upon when submitting claim." It is noted the Operative Report reflects that Provider and the Co-Surgeon have "agreed to apportion the total surgical fees 50% to each co-surgeon" for this service.

The provided Operative Report was reviewed by a Medical Professional Reviewer regarding the validity of Modifier -22. The Physician Reviewer stated the following regarding the extended service code:

"Documentation available for review identifies 10/4/13 procedure report for exploration of interbody and facet fusion L5-S1; bilateral revision laminectomy, facetectomy, and foraminotomy L4 and L5; partial revision laminectomy S1; partial laminectomy L3; excision of intervertebral disc at L4-5 followed by middle column interbody reconstruction using PEEK cages filled with demineralized cancellous allograft; interbody fusion of anterior column of L4-5 with autogenous bone graft; bilateral posterior osteotomy L4 and L5; poster segmental spinal instrumentation with pedicle screw/rod construct L4, L5, and S1; bilateral posterolateral intertransverse fusion at L3-4 and L4-5 using combination of allograft and autogenous bone graft; repair of small region of dural ectasia; and harvesting autogenous bone graft. The body of the surgery report identifies a paragraph specifically noting that "additional operative time was necessary during several portions of the surgery. This included the additional time necessary for careful dissection to safely separate the scarred dura from the residual lamina and decompress the various nerve roots. This resulted in a 50% increase in 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."

The supported information for Modifier 22 allows for increased reimbursement. The OMFS fee allowance for CPT 63047 -62, -22 is increased by 25%, the Co-Surgeon is increased by 25% and the total allowance is "apportioned between the two physicians (50% to each physician)." According to the IBR calculations performed, it appears that the Claims Administrator placed the CPT in the primary position and reimbursed the Provider 100% of the OMFS according to Modifier -62 guidelines, however, based on the documentation provided and calculations performed during this IBR, it is recommended the Claims Administrator reimburse the Provider for Modifier -22 in addition to Modifier -62.

The last service in question is CPT 63048 -62, -22; billed at two (2) units. The Claims Administrator provided the following reasons for reimbursement:

1. Reimbursement reflects services provided by Co Surgeons with the appropriate percentage apportioned.
2. This service is an Add-on procedure and is excluded from the multiple procedures rule reduction.
3. Modifier 22, Unusual Procedure.
4. The Charge Exceeds the Official Medical Fee schedule allowance. The charge has been adjusted to the schedule allowance.

5. Recommended payment reflects Physician Fee Schedule Surgery Section, Rule 7 guidelines for multiple or bilateral surgical services.
6. Processed based on multiple or concurrent procedure rules.

CPT 63048 -62, -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 10/22/2013. The Provider valued CPT 63048 -62, -22 at \$1340.00. An allowance of \$536.00 was reimbursed to the Physician by the Claims Administrator. A second review by the Claims Administrator on 01/10/2014 did not yield additional reimbursement or offer further clarification other than the 1 - 6 reasons provided above. It is noted that the “billed” amount on the HCFA 1500 and the EOR do not coincide; the billed amount should reflect \$1,340.00 on the EOR, not \$536.00.

Modifier 22 use was verified for CPT 63048 -62, -22; the quote from the Physician Reviewer was provided earlier in this discussion for CPT 63047 as both services are integral procedures that were performed on the patient on this date of service. Modifier 62, Co-Surgeon agreement was also verified and quoted in the previous CPT review above.

The supported information for Modifier 22 allows for increased reimbursement. The OMFS fee allowance for CPT 63048 -62, -22 is increased by 25%, the Co-Surgeon is increased by 25% and the total allowance is “apportioned between the two physicians (50% to each physician).” Since the provided documentation and discussed guidelines reflect the elements of 63048 -62, -22, additional reimbursement for this service is recommended.

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
63047	62, 22	1	\$1,999.00	\$1998.55	\$1598.55	\$400.00	OMFS
63048	62, 22	2	\$1,340.00	\$1340.00	\$536.00	\$804.00	OMFS

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 code 63047 Modifier 62,22 and CPT 63048 Modifier 62, 22 (**\$1204.00**) for a total of **\$1,539.00**.

The Claims Administrator is required to reimburse the provider **\$1,539.00** 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

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
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