

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Fax: (916) 605-4280

**Independent Bill Review Final Determination Reversed**

7/25/2014

████████████████████  
██  
████████████████████

IBR Case Number:	CB14-0000099	Date of Injury:	7/31/2008
Claim Number:	████████	Application Received:	1/23/2014
Claims Administrator:	██		
Date(s) of service:	10/15/2013 – 10/15/2013		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	22830, 22855, 63090, 63091 and 63047		

Dear ██████████ MD:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/19/2014, 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 \$2,271.38, for a total of \$2,606.38.**

**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 or negotiated contract: OMFS
- Other: OMFS Surgery Information and Ground Rules

## Supporting Analysis:

The dispute regards the payment amount for surgical services performed on 10/15/2013. The Provider billed CPT codes: 22830 Modifiers 22, 62, 22855 Modifier 22, 63090 Modifiers 62 22, 63091 Modifiers 62 22, 63047 Modifier 62 22, 63048 Modifier 62 and 22 and 22852 Modifier 22. The surgery was performed in two stages: anterior and posterior. A co-surgeon was involved in some of the procedures.

Below is a list of disputed procedures codes for date of service 10/15/2013

### Anterior Stage

CPT 22830 – Exploration of spinal fusion; documentation in the operative report is required.

CPT 22855 - Removal of anterior instrumentation

CPT 63090 - Vertebral corpectomy (vertebral 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- Vertebral corpectomy (vertebral resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; each additional segment

### Posterior Stage

CPT 63047 – Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)) single vertebral segment; lumbar

CPT 22830 - Exploration of spinal fusion; documentation in the operative report is required.

Modifier 22-Unusual Procedure Services

Modifier 62- Two Surgeons

Per the Independent Bill Review application, the Provider is disputing the reimbursement of the following codes: 22830, 22855, 63090, 63091 and 63047. The Claims Administrator reimbursed a total of \$5,797.59 for the disputed codes.

The case was reviewed by an Orthopedic Surgeon specializing in Spinal Surgery decision and findings are as follows:

The document submitted included: stage I: Anterior Spine Reconstructive Surgery; the second for Posterior Spine Reconstructive Surgery. The body of the anterior spine reconstructive 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 regions 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. In addition, the body of the posterior spine reconstructive surgery report identifies a paragraph specifically noting that "additional operative time was necessary during a portion of this patient's revision spinal procedure because of the significant scarring from the previous surgery. Careful dissection was necessary 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 the revision levels of the posterior decompression". 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 additional reimbursement was determined based on 25% increase in the OMFS Physician Fees allowance, and subject to the multiple procedure and co-surgeons modifier 62 guidelines. The Provider documented in the Operative Report, the two surgeons agreed to apportion the total surgical fees 50% to each co-surgeon. Multiple procedure guidelines are as follows: Major (highest valued) procedure 100% of listed value; second (second-highest valued or equivalent) procedure 50% of listed value; and Third (third-highest valued or equivalent). The calculation for Modifier 62 (co-surgeon) is as follows; allowance is increased by 25% and the total allowance is apportioned between the two physicians (50% to each physician).

The additional reimbursement of \$2,271.38 is warranted for the following billed Official Medical Fee Schedule codes billed with the Modifier 22: 22830, 22855, 63090, 63091 and 63047.

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 Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
63047	22	62	1	\$400.15	\$1,999.00	\$1,598.85	\$400.15	OMFS
22830	22	62	1	\$1,435.17	\$448.54	\$358.83	\$89.71	OMFS
22830	22	62	1	\$1,076.33	\$448.54	\$717.67	\$0.00	OMFS
22855	22		1	\$446.95	\$2,234.76	\$1,787.81	\$446.95	OMFS
63090	22	62	1	\$1,199.57	\$1,999.00	\$799.43	\$1,199.57	OMFS
63091	22	62	1	\$135.00	\$670.00	\$535.00	\$135.00	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 codes: 63047, 22830 (2), 22855, 63090 and 63091 Modifier 22 (\$2,271.38) for a total of \$2,606.38.

***The Claims Administrator is required to reimburse the provider \$2,606.38 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,

██████████, RHIT

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