

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 8, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|--|------------------------------|------------|
| IBR Case Number: | CB14-0001227 | Date of Injury: | 9/25/2009 |
| Claim Number: | [Redacted] | Application Received: | 8/29/2014 |
| Claims Administrator: | [Redacted] | Assignment Date: | 10/06/2014 |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 22554, 22585, 63075, 63076, 22851, 22851, 22845, 22110, 22116, 69990, 72100, 22116, 22116, 63081 all with Modifier -22 | | |

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 \$250.00 for the review cost and \$2104.48 in additional reimbursement for a total of \$2354.48. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2354.48 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]
Medical Director

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
- Negotiated contracted rates: None
- National Correct Coding Initiatives
- Other: OMFS Physician Services; General Information and Instructions

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 dissatisfied with reimbursement of surgical codes 22554, 22585, 63075, 63076, 22851, 22851, 22845, 22110, 22116, 69990, 72100, 22116, 22116, 63081 all with Modifier -22 stating “Claims Administrator did not pay in accordance with the Official Medical Fee Schedule and failed to apply modifier 22 to all CPT codes that were billed.”
- Claims Administrator reimbursed \$6664.15 indicating on the Explanation of Review “Per CCI Edits, the value of this procedure is included in the value of the comprehensive procedure” and “This add-on code has been denied as the principal procedure was not billed and/or allowed. Labor Code 5307.1.”
- Provider’s Operative Report was reviewed by the Maximus Chief Medical Director who found there was justification for the use of Modifier -22 based on the clear specific detail included about the complexity of the procedure that exceeded the usual for all requested codes. Therefore, a 25% increase on reimbursement for the CPT codes that qualify is warranted.
- NCCI Edits were found on codes 63075, 63076, 22110 and 69990 which state these codes were not billed correctly and therefore reimbursement is not warranted. For CPT code 63075, NCCI Edit exists with CPT 22110. CPT 22110 NCCI Edit exists with CPT 63081 which was reimbursed by Claims Administrator. Therefore, no reimbursement is warranted for codes 63075 and 22110. CPT 63076 and 69990 NCCI Edit exists with

code 22554 which was reimbursed by Claims Administrator and therefore no reimbursement is warranted for CPT 63076 and 69990. Claims Administrator was correct to deny reimbursement based on codes that should not be reported together such as CPT codes 63075, 63076, 22110 and 69990.

- 22116 x 3 - Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; each additional vertebral segment (List separately in addition to code for primary procedure). Use 22116 in conjunction with 22110, 22112 and 22114. 22110 was denied as not billed correctly according to standards of medical/surgical practice and therefore makes CPT 22116 invalid. No reimbursement is warranted for CPT 22116.
- CPT 72100 x 20 units was also billed. Pursuant to **CMS' Medically Unlikely Edits** which states "An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service." **CPT code 72100 has a Practitioner Service MUE Value of 1** and therefore, no further reimbursement for additional units of 72100 is warranted. However, as the Modifier -22 was appended to CPT 72100 and the Modifier -22 was found justified, additional reimbursement is based on 25% increase in the OMFS Physician Fees allowance.
- 22585, 22851 x 2 and 22845 are Add-on codes and shall be reimbursed at 100% of OMFS pursuant to OMFS General Information and Instructions.
- Pursuant to 2014 NCCI Edits, Modifier -20 is not allowed with CPT 22554 and therefore 22554 is subject to the multiple surgery rule of 50% reduction as it is not the highest valued code submitted. 63081 is the highest valued code submitted and is due an increase of 25% for Modifier -22.
- Pursuant Official Medical Fee Schedule Multiple Surgery Rules 2014, fee reduction is as follows: (A) 100 percent of the fee schedule amount for the highest values procedure; and (B) 50 percent of the fee schedule amount for the second through the fifth highest values procedures.
- Provider disputes any contract agreement with Claims Administrator as a 5% discount had originally been taken in reimbursement as shown on the Explanation of Review. Maximus requested a copy of a PPO Contract which was not received by either Provider or Claims Administrator. Provider submitted documentation stating No Contract Provisions exist and therefore, reimbursement is based on the Official Medical Fee Schedule plus the 25% increase due to supportive documentation for Modifier -22.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of codes 22554, 22585, 22851 x 2, 22845, 72100 and 63081 all with Modifier -22 is warranted.

| Date of Service: 2/4/2014 | | | | | | | |
|----------------------------------|------------------------|---------------------|-----------------------|-----------------------|-------------------------|-----------------------------------|---|
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 22554-20 | \$1294.34 | \$983.70 | \$310.64 | N/A | 50% | \$1294.34 | DISPUTED SERVICE: Allow additional reimbursement \$310.64 |
| 22585 | \$674.24 | \$512.42 | \$161.82 | N/A | 100% | \$674.24 | DISPUTED SERVICE: Allow additional reimbursement \$161.82 |
| 63075 | \$1389.81 | \$0.00 | \$1389.81 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 63076 | \$499.44 | \$0.00 | \$499.44 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 22851 | \$824.50 | \$626.62 | \$197.88 | N/A | 100% | \$824.50 | DISPUTED SERVICE: Allow additional reimbursement of \$197.88 |
| 22851 | \$824.50 | \$626.62 | \$197.88 | N/A | 100% | \$824.50 | DISPUTED SERVICE: Allow additional reimbursement of \$197.88 |
| 22845 | \$1479.19 | \$1124.18 | \$355.01 | N/A | 100% | \$1479.19 | DISPUTED SERVICE: Allow additional reimbursement of \$355.01 |
| 22110 | \$550.49 | \$0.00 | \$550.49 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 22116 | \$283.54 | \$0.00 | \$283.54 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 69990 | \$215.58 | \$0.00 | \$215.58 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 72100 | \$1525.50 | \$57.97 | \$1467.53 | N/A | N/A | \$76.28 | DISPUTED SERVICE: Allow additional reimbursement of \$18.31 |
| 22116 | \$283.54 | \$0.00 | \$283.54 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 22116 | \$283.54 | \$0.00 | \$283.54 | N/A | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |
| 63081 | \$3595.58 | \$2732.64 | \$862.94 | N/A | 100% | \$3595.58 | DISPUTED SERVICE: Allow additional reimbursement \$862.94 |

National Correct Coding Initiative information:

| File | Column 1 | Column 2 | Modifier |
|--|-----------------|-----------------|-----------------|
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 22110 | 63075 | Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 22110 | 69990 | Not Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 22554 | 63076 | Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 22554 | 69990 | Not Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 63075 | 22554 | Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 63075 | 22585 | Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 63075 | 69990 | Not Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 63076 | 69990 | Not Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 63081 | 22110 | Allowed |
| Physician Version Number: 20.0 1/1/2014-3/31/2014 | 63081 | 63075 | Allowed |

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