

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 20, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001230	Date of Injury:	04/29/2010
Claim Number:	[Redacted]	Application Received:	09/02/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22612 -20, 22842, 22851, 64550, 64550-59, 63030, 22612-59, 22842-59, 22851-59, 64550 -59, 64550-59, 72100 x 51 & Units, 72100 x 40 Units, 22630, 22851-59, & 22851-59.		

Dear [Redacted]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case assigned to IBR on 10/01/2014. 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 \$3,844.69 in additional reimbursement for a total of \$4,094.69. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$4,094.69 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
- NCCI Edits

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 questioning reimbursement for CPT Codes 22612 -20, 22842, 22851, 64550, 64550-59, 63030, 22612-59, 22842-59, 22851-59, 64550 -59, 64550-59, 72100 x 51 Units, 72100 x 40 Units, 22851-59 and 22851-59.
- The Claims Administrator states codes; 22612 -20, 22842, 22851, 64550, 63630, 22851, 22851-59, 22630 and 22851-59, were “reimbursed in accordance with (Claims Administrator) contract.” The Claims Administrator’s 2nd claims review did not change the outcome of these services.
- IBR cannot overturn applied PPO contractual rates between the Claims Administrator and Provider. As such, additional reimbursement for codes; **22612-20, 22842, 22851, 64550, 63630, 22851, 22851-59, 22630 and 22851-59 cannot be recommended.**
- Review of **CPT Codes 22612-20, 22842, 22851, 64550, 63030, 22851, 22851-59 and 22851-59**, has found additional reimbursement at 100% OMFS is indicated and warranted.
- **CPT Codes 64550-59, 22612-59, 22842, 64450-59, and 64450-59** were denied by the Claims Administrator for the following reason: “The medically unlikely edits (MUE) from CMS have been applied to this procedure.”
- After careful review of **CPT Codes 64550-59, 64450-59, and 64450-59** “Application of surface (**transcutaneous**) neurostimulator,” this CPT Code is listed on the MUE with a service value of “1” and is reported only once during an encounter.
- Reimbursement is not warranted for **CPT codes 64550-59, 64450-59, and 64450-59**
- **CPT Code 22612-59**, “Arthrodesis, posterior or Postero-lateral technique, single level; lumbar,” this CPT Code is listed on the MUE with a service value of “1” and is reported only once per interspace and segment with a “0” indicator in the bilateral field. Operative report indicated services were

performed on different anatomic areas: right and left anatomic sites of L4/5. Labor Code §9789.16.6 Bilateral Surgeries with an indicator or '0' may be reported if the "Claims Administrator has determined that the code may be reported more than once." The Assistant Surgeon for this case was reimbursed by the Claims Administrator for two units of CPT 22612 thereby validating the second unit of 22612.

- **Reimbursement is warranted for CPT 22612-59.**
- **CPT Code 22842-59**, "Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sub-laminar wires); **3 to 6 vertebral segments** (list separately in addition to code for primary procedure)," this CPT Code is listed on the MUE with a service value of "1" and is reported only once in accordance with the CPT Guidelines. Operative report indicated services were performed on different anatomic areas: right and left anatomic sites of L4/5. Labor Code §9789.16.6 Bilateral Surgeries with an indicator or '0' may be reported if the "Claims Administrator has determined that the code may be reported more than once." The Assistant Surgeon for this case was reimbursed by the Claims Administrator for two units of CPT 22842-59 thereby validating the second unit of 22842-59.
- **Reimbursement is not warranted for CPT 22842-59.**
- **CPT Code 72100 x 51 & Units, 72100 x 40 Units**, "Radiologic examination, spine, lumbosacral; **2 or 3 views**," this CPT Code is listed on the MUE with a service value of "1" and is reported only once. Provided documentation and Operative report does not provide the results of the reported 270 plus x-rays. Response from the Claims Administrator indicates Hospital Charge reflects a value of "1" unit. As such, without the proper documentation, reimbursement for 91 units cannot be recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: For CPT Codes 22612 -20, 22842, 22851, 64550, 64550-59, 63030, 22612-59, 22842-59, 22851-59, 64550 -59, 64550-59, 72100 x 51 & Units, 72100 x 40 Units, 22851-59, & 22851-59.

Date of Service: January 13, 2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
22612-20	\$2,640.65	\$2,480.10	\$130.53	N/A	1	\$2,480.10	\$0.00 Due Provider Refer to Analysis
22842	\$1,235.04	\$1,173.29	\$61.74	N/A	1	\$1,173.29	\$0.00 Due Provider Refer to Analysis
22851	\$659.60	\$626.62	\$32.98	N/A	1	\$626.62	\$0.00 Due Provider Refer to Analysis

64550	\$15.21	\$14.45	\$0.76	N/A	1	\$14.45	\$0.00 Due Provider Refer to Analysis
63030	\$797.20	\$757.34	\$39.86	N/A	1	\$757.34	\$0.00 Due Provider Refer to Analysis
22851	\$659.60	\$626.62	\$32.98	N/A	1	\$626.62	\$0.00 Due Provider Refer to Analysis
22851-59	\$659.60	\$626.62	\$32.98	N/A	1	\$626.62	\$0.00 Due Provider Refer to Analysis
22851	\$659.60	\$626.62	\$32.98	N/A	1	\$626.62	\$0.00 Due Provider Refer to Analysis
64450-59	\$7.61	\$0.00	\$7.61	N/A	1	\$0.00	\$0.00 Due Provider Refer to Analysis
64450-59	\$15.21	\$0.00	\$15.21	N/A	1	\$0.00	\$0.00 Due Provider Refer to Analysis
64450-59	\$7.61	\$0.00	\$7.61	N/A	1	\$0.00	\$0.00 Due Provider Refer to Analysis
22612-59	\$2,610.65	\$0.00	\$2,610.65	N/A	1	\$2,610.65	\$2,610.65 Due Provider Refer to Analysis
22842-59	\$1,235.04	\$0.00	\$1,234.04	N/A	1	\$1,234.04	\$1,234.04 Due Provider Refer to Analysis
72100	\$3,112.02	\$57.97	\$23.83	N/A	51	\$20.90	1 Unit OMFS = \$20.90. Provider Reimbursed \$57.97, \$0.00 Due Provider
72100	\$2,40.80	\$0.00	\$0.00	N/A	40	\$0.00	\$0.00 Due Provider Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
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[REDACTED]
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