

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 §978912.13

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 disputing reimbursement for Assistant Surgeon Services, 72100-99-22-80 x 7 units, 69990-99-22-20-80, 63042-99-22-80, 63042-99-22-50-80, 62311-99-22-80, & 63709-99-22-80 submitted on CMS 1500 form for date of service 04/29/2014.
- Claims Administrator denied reimbursement for **69990-99-22-20-80 Microsurgical Technique; 63042-99-22-80 Laminectomy Single Lumbar; 63042-99-22-50-80 Laminectomy Single Lumbar; 62311-99-22-80 Injection Single; & 63709-99-22-20-80 Repair Spinal Fluid Leak** due to: “Charge was adjusted to comply with the rules and rates of contract indicated” and “Procedure code not reimbursed when billed with another mutually exclusive procedure code on the same date of service.”
- IBR unable to reverse or determine contractual agreements and obligations between Provider and Claims Administrator.

- Modifier -99 (Multiple Modifiers), Modifier 22 (Increased Procedural Service) Modifier 50 (Bilateral Procedure) Modifier 20 (Microsurgery) Modifier 80 (Assistant Surgeon).
- **69990-99-22-20-80** is a column 2 code paired code with 63042-99-20-22 and 63042-99-22-50 with a modifier indicator of “0” and is not separately reportable.
- **62311-99-2280** is a column 2 code paired with 63709 -99-22-20, with a modifier indicator of “0” and is not separately reportable.
- **63709-99-22-20-80** is a column 2 code paired with 63042, with a modifier indicator of “0” and is not separately reportable.
- **63042-99-22-80** and **63042-99-22-50-80** Documentation supports surgical procedures at “L4/5,” and one unit at “L5/S1.” Additional procedure relative to claim is CPT 63030; Reimbursed by Claims Administrator as Primary Procedure. 63042 Codes have a Multiple Surgery indicator of “2” and are subject to Multiple Surgery rule as indicated in §9789.16.5
- **72100-22 x 7** units Radiologic examination, spine, lumbosacral; 2 or 3 views. Claims Administrator reimbursement based on the following rationale: “The Medical Unlikely Edits (MUE) have been applied to this procedure.”
- CPT Code 72100 is listed on the MUE with a service value of “1” and is reported only once per event.
- **Modifier -22 Increased Procedural Service requiring work substantially greater than typically required.** Operative Note reviewed by Physician. Physician Review stated, “Use of the -22 modifier was not medically necessary in this case as there was no description of the unusual work provided above and beyond the standard procedure for the surgical procedure, the X-ray interpretation, or other procedure codes billed with the -22 modifier. Although the Provider does state that the patient was ‘obese’ and the surgical procedure was ‘extended’ do to previous surgery increasing technical difficulty, there is no specific documentation supporting additional work depicted by addition of a -22 modifier. Additionally, there was lack of (a) specific number of X-rays performed and that they were to view X-rays or interpretation. The medical necessity of the number of X-rays was lacking according to the documentation.”
- **Modifier -80 Assistant Surgeon**
- Provider is an M.D.
- Modifier -80 Reimbursement at 16% of OMFS surgical procedure §9789.16.8

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement determination for codes: 72100-99-22-80 x 7 units, 69990-99-22-20-80, 63042-99-22-80, 63042-99-22-50-80, 62311-22, & 63709-99-22-80

Date of Service: 04/29/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
72100-22 x7	\$154.00	\$61.02	\$92.08	Y	7	\$61.02	Refer to Analysis

Units							
69990-99-22-20	\$990.40	\$0.00	\$990.40	Y	1	\$0.00	Refer to Analysis
63042-99-20-22	\$1,453.80	\$0.00	\$1,453.80	Y	1	\$895.14	Procedure Subject to Multiple Procedure Rule OMFS Utilized as No Contractual Fee Was Indicated
63042-99-22-50	\$1,453.80	\$0.00	\$1,453.80	Y	1	\$895.14	Procedure Subject to Multiple Procedure Rule OMFS Utilized as No Contractual Fee Was Indicated
62311-22	\$224.40	\$0.00	\$224.40	Y	1	\$0.00	Refer to Analysis
63709-99-22-20	\$1,192.80	\$0.00	\$1,192.80	Y	1	\$0.00	Refer to Analysis
63030	N/A	N/A	N/A	N/A	N/A	N/A	Code Not In Dispute, Utilized as EOR Reference for Analysis.

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