

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: | CB14-0001269 | Date of Injury: | 01/05/2014 |
| Claim Number: | [Redacted] | Application Received: | 09/04/2014 |
| Claims Administrator: | [Redacted] | Assignment Date: | 10/08/2014 |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 63090, 25558-62, 22851, 22851, 22845, 72100 x 23 | | |

Dr. [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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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: PPO Contract
- National Correct Coding Initiatives
- Other: OMFS Physician Services 2014

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 codes 63090, 25558-62, 22851, 22851, 22845, 72100 x 23
- Claims Administrator reimbursed \$5566.34 indicating on the Explanation of Review for codes 63090, 25558-62, 22851 and 22845 “This charge was adjusted to comply with the rate and rules of the contract indicated.” CPT 22851 and 72100 x 23 were denied as “The charge was denied as the report/documentation does not indicate that the service was performed.”
- Based on review of the operative report, 22851 is only mentioned once and was reimbursed by Claims Administrator. Therefore a second reimbursement on this code is not warranted.
- The Operative report states “Approximately 23 AP and Lateral Fluoroscopic x-rays were taken during surgery.” 72100 is both the professional and technical components of this radiology service. However, documentation submitted does not support 23 X-rays Provider billed. Therefore, no reimbursement of 72100 x 23 is warranted.
- Codes 63090, 25558-62, 22851 and 22845 were all reimbursed per OMFS 2014 and subject to the 5% discount per PPO contract agreement between Provider and Claims Administrator.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, no additional reimbursement is warranted.

| Date of Service: 1/6/2014 | | | | | | | |
|---------------------------|-----------------|--------------|----------------|----------------|------------------|----------------------------|--|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 63090 | \$3226.88 | \$3065.54 | \$161.34 | Allowed | 100% | \$0.00 | DISPUTED SERVICE: No reimbursement recommended based on Contract discount |
| 22558 - 62 | \$3214.83 | \$750.00 | \$857.42 | Allowed | 50% | \$0.00 | DISPUTED SERVICE: No reimbursement recommended based on Contract discount |
| 22851 | \$659.23 | \$626.62 | \$32.61 | Allowed | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended based on Contract discount |
| 22851 | \$659.23 | \$0.00 | \$659.23 | Allowed | N/A | \$0.00 | Disputed Service: No reimbursement recommended |
| 22845 | \$1183.35 | \$1124.18 | \$59.17 | Allowed | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended based on Contract discount |
| 72100 x 23 | \$431.25 | \$0.00 | \$431.25 | Allowed | N/A | \$0.00 | Disputed Service: No reimbursement recommended |

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