

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|---|------------------------------|------------|
| IBR Case Number: | CB14-0001299 | Date of Injury: | 09/30/1994 |
| Claim Number: | [Redacted] | Application Received: | 09/08/2014 |
| Claims Administrator: | [Redacted] | Assignment Date: | 10/07/2014 |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 63081, 63082, 22830-59-51, 22855-59-51 and 22554-51 all with Modifier -62 | | |

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 \$1825.90 in additional reimbursement for a total of \$2075.90. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2075.90 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: PPO Contract Discount 2%
- National Correct Coding Initiatives
- Other: OMFS Multiple Procedure Reduction and Co-Surgeon Reimbursement

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 63081, 63082, 22830-59-51, 22855-59-51 and 22554-51 all with Modifier -62
- Claims Administrator reimbursed \$2523.20 indicating on the Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- PPO Contract received shows a 2% discount is to be applied to reimbursement. However, Explanation of Review shows a greater discount was applied and is inappropriate.
- Calculations were adjusted to show a 25% increase and then split in half for procedures as co-surgeons and then split in half again for the multiple procedure reductions. Except for CPT codes that are list separately and therefore are reimbursed at 100% less the co-surgeon and PPO discount.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of codes 63081, 63082, 22830-59, 22855 and 22554 all with Modifier -62 is warranted.

| Date of Service: 6/6/2014 | | | | | | | |
|---------------------------|-----------------|--------------|----------------|----------------|------------------|----------------------------|---|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 63081 | \$1797.79 | \$1123.62 | \$674.17 | -62 Modifier | 100% | \$1761.83 | DISPUTED SERVICE: Allow reimbursement \$638.21 |
| 63082 | \$269.59 | \$168.49 | \$101.10 | -62 Modifier | 100% | \$264.20 | DISPUTED SERVICE: Allow reimbursement \$95.71 |
| 22830 | \$418.68 | \$130.84 | \$287.84 | -62 Modifier | 50% | \$410.31 | DISPUTED SERVICE: Allow reimbursement \$279.47 |
| 22855 | \$570.08 | \$178.15 | \$391.93 | -62 Modifier | 50% | \$558.67 | DISPUTED SERVICE: Allow reimbursement \$380.52 |
| 22554 | \$647.17 | \$202.24 | \$444.93 | -62 Modifier | 50% | \$634.23 | DISPUTED SERVICE: Allow reimbursement \$431.99 |

National Correct Coding Initiative information:

| File | Column 1 | Column 2 | Modifier |
|--|----------|----------|----------------|
| Physician Version Number: 20.1 4/1/2014-6/30/2014 | 22554 | 22830 | Allow Modifier |
| Physician Version Number: 20.1 4/1/2014-6/30/2014 | 22855 | 22830 | Allow Modifier |
| Physician Version Number: 20.1 4/1/2014-6/30/2014 | 22855 | 22845 | Allow Modifier |

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