

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 31, 2014

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

IBR Case Number:	CB14-0001318	Date of Injury:	12/15/2010
Claim Number:	[Redacted]	Application Received:	09/11/2014
Claims Administrator:	[Redacted]	Assignment Date:	10/09/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22851-99-22-59-80, 22612-99-22-80, 22842-99-22-59-80 x 3 Units, 22325-99-22-80, 22852-99-22-59-80 x 5 Units, 22849-99-22-59-80 x 4 Units, 72148-99-26-80, 64550-99-22-59-80 x 4 Units, & 72100 -80 x 130 Units.		

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 \$1,277.41 in additional reimbursement for a total of \$1,527.41. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,527.41 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

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 seeking full remuneration for Assistant Surgical Services 22851-99-22-59-80, 22612-99-22-80, 22842-99-22-59-80 x 3 Units, 22325-99-22-80, 22852-99-22-59-80 x 5 Units, 22849-99-22-59-80 x 4 Units, 72148-99-26-80, 64550-99-22-59-80 x 4 Units, & 72100 -80 x 130 Units, performed on Injured Worker 04/24/2014.**
- **CPT Codes 22851-99-22-59-80, Apply Spinal Device; 22612-99-22-80, Remove Spine Fixation Device; 22842-99-22-59-80 x 3 Units, Insert Spinal Fixation Device; 22325-99-22-80, Treat Spine Fracture,** Claims Administrator reimbursement rational: “Charge Exceeds the Official Fee Schedule Allowance, charge has been adjusted to the schedule allowance.”
- **CPT 22851 and 22325** reflect full (accumulative) payment for services on EOR 5/22/2014, 7/28/2014 and 8/20/2014. No additional allowance recommended.
- **CPT 22612** is the third highest ranking service. EOR 5/22/2014, 7/28/2014 and 8/20/2014 reflect overpayment as Primary Procedure.
- **CPT 22842** is an add-on procedure and is not subjected to MPPR. EOR 5/22/2014, 7/28/2014 and 8/20/2014 reflect underpayment of service.
- **CPT 22849, Reinsert Spinal fixation,** is a Colum 1 code and is paired with **CPT 22852, Removal of Posterior Segmental Instrumentation,** Colum 2 code. Modifier -59 can

unbundle the pair if the procedures were performed at different levels. OR report indicates the procedures were performed at the same levels.

- Claims Administrator reimbursed the Provider for Colum 2 code 22852 and denied Colum 1 Code, 22849. Recommend reimbursement of Colum 1 code 22849.
- Claims Administrator denied reimbursement for **72148-99-26-80, MRI Lumbar W/O Dye**, stating, “Documentation does not indicate that the service was performed.”
- Operative report reviewed, 72148 service could not be identified.
- Reimbursement is not indicated for CPT 72148.
- Claims Administrator denied **64550-99-22-59-80 Application of surface (transcutaneous) neurostimulator x 4 Units**, stating, “Not within your scope of Practice.”
- Provider is a Neurosurgeon; 64550 is listed on the MUE with a service value of “1” and is reported only once during an encounter, and is reimbursable to the Provider.
- **CPT Code 72100 x 130 Units**, denied by the Claims Administrator with the following rational: “service within global period.”
- 72100 MEU indicates 1 unit per encounter. Claims Administrator accepted 72100 x 130 for the Primary Surgeon indicating. Acceptance of procedure for primary surgeon indicates: 1) Service was not within a global period. 2) x 130 units reimbursable.
- Contractual Agreement Not Yet Received for IBR, OMFS will be utilized to calculate reimbursement.

The table below describes the pertinent claim line information.

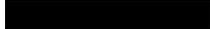
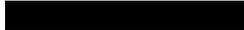
DETERMINATION OF ISSUE IN DISPUTE: 22851-99-22-59-80, 22612-99-22-80, 22842-99-22-59-80 x 3 Units, 22325-99-22-80, 22852-99-22-59-80 x 5 Units, 22849-99-22-59-80 x 4 Units, 72148-99-26-80, 64550-99-22-59-80 x 4 Units, & 72100 -80 x 130 Units

Date of Service: 04/04/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
22851	\$622.50	\$211.08	\$59.36	Y	1	\$211.08	Refer to Analysis
22612	\$1,528.25	\$835.40	234.96	Y	1	\$417.70	\$417.70 Over Payment – Refer to Analysis – Overpayment will be applied to Reimbursement
22842	\$3,049.80	\$197.61	\$728.67	Y	1	\$395.21	\$197.61 Under Payment – Refer to Analysis – Underpayment will be applied to Reimbursement
22325	\$1,215.50	\$188.85	\$106.20	Y	1	\$188.85	Refer to Analysis

22852	\$3,453.00	\$457.45	\$972.08	Y	5	\$0.00	Recommend Payment for Denied Service 22849. Refer to Analysis
22849	\$2,961.60	\$0.00	\$2,130.55	Y	4	\$681.78	\$457.45 Applied (Code 22852) – Allowed Amount = 224.33 Due Provider
72148	\$90.50	\$0.00	\$23.23	Y	1	\$0.00	Refer to Analysis
64450	\$129.80	\$0.00	\$11.40	Y	4	\$4.38	Refer to Analysis
72100	\$2,860.00	\$0.00	\$1,586.52	Y	130	\$1,268.80	Refer to Analysis

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