

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 29, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001448	Date of Injury:	08/06/2004
Claim Number:	[Redacted]	Application Received:	09/29/2014
Claims Administrator:	[Redacted]	Assignment Date:	10/29/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22842		

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 \$1235.04 in additional reimbursement for a total of \$1485.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1485.04 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]
[Redacted]

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:
- National Correct Coding Initiatives

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 denial of CPT 22842
- Claims Administrator denied code indicating on the Explanation of Review “Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure.”
- Based on review of the operative report, Provider performed a spinal fusion with segmental posterior instrumentation L2-S1.
- CPT 22842 – posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure). Use 22842 in conjunction with 22100-22102, 22110-22114, 22206, 22207, 22210-22214, 22220-22224, 22305-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, 63300-63307)
- Primary code billed 22612 and reimbursed by Claims Administrator was 22612.
- Based on information reviewed, reimbursement of code 22842 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 22842 is recommended.

Date of Service: 2/18/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22842	\$3956.00	\$0.00	\$1235.04	1	100%	\$1235.04	DISPUTED SERVICE: Allow reimbursement \$1235.04

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.0 1/1/2014-3/31/2014	22842	22852	Allow Modifier

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