

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 19, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000473	Date of Injury:	02/19/1998
Claim Number:	[REDACTED]	Application Received:	03/24/2014
Claims Administrator:	[REDACTED]	Assignment Date:	06/13/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63042-50-59		

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 \$335.00 for the review cost and \$1395.37 in additional reimbursement for a total of \$1730.37. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1730.37 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]
Chief Coding Reviewer

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
- Other: AMA, CPT Coding Guidelines 1997

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 denied CPT code 63042-50-59
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Provider billed surgery codes for a revision decompression with laminectomy L4(63042-50-59) and complete laminectomy L3/L2 (63047-51).
- Claims Administrator denied CPT 63042-50-59 indicating on the Explanation of Review "Service/item included in the value of other services per CCI edits."
- 63047 & 63042 cannot be reported together for the same level per coding guidelines. Provider submitted an Operative Report which states patient is "status post previous lumbar decompression with transitional level stenosis, back, buttock and leg pain refractory to nonsurgical care is indicated for revision surgery." Provider details procedures performed including dissection of spinous process at L3/L2 with complete virginal decompression and revision decompression at L4, removing a small portion of the superior articular facet. Provider clearly states two levels and has billed 63042 with a modifier 59 – Distinct Procedural Service. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the

circumstances. Provider has documented and billed CPT 63042 appropriately and therefore, reimbursement is recommended.

- Pursuant to OMFS General Information and Instructions, reimbursement shall be 150% of listed value for the bilateral modifier 50 and 50% deduction for multiple surgical procedures as 63042 is the second highest valued procedure next to 63047. Procedure code 22612 was reimbursed at 50% but was third highest value in weight and should have been reimbursed at 25%. 22612 should have received \$512.36 instead of \$1024.72. Therefore, overpayment of 22612 shall be applied to reimbursement of 63042 in the amount of \$512.36.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation reviewed, reimbursement of code 63042-50-59 is warranted.

Date of Service: 9/25/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery Reduction	Workers' Comp Allowed Amt.	Notes
63042-50-59	\$10928.00	\$ 0.00	\$ 3815.45	50%	\$1907.73	DISPUTED SERVICE: Allow reimbursement \$1395.37 (\$1907.73 – \$512.36 = \$1395.37)
22612	\$7578.00	\$1024.72	No dispute (-\$512.36 is deducted from original overpayment)	25%	\$512.36	NOT A DISPUTED SERVICE: Code should be reimbursed at 25%. \$512.36 has been deducted from original payment as it was overpaid and applied to reimbursement of 63042.

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