

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

██████████
██████████████████
██████████████████

IBR Case Number:	CB14-0000502	Date of Injury:	08/21/2012
Claim Number:	██████████████████	Application Received:	03/28/2014
Claims Administrator:	██████████	Assignment Date:	06/05/2014
Provider Name:	██		
Employee Name:	██████████████████		
Disputed Codes:	20930, 60376 & 20936		

Dear ██████████ ██████████

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 \$706.40 in additional reimbursement for a total of \$1041.40. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1041.40 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,

██
██████████████████

cc: ██████████
██

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: 90%

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 remuneration for 20930, 60376, 20936 surgical services performed on 11/08/2013.
- Claims Administrator denied reimbursement for 20930 & 20936 Allograft services on 12/28/2013 indicating the following: “We cannot review this service without necessary documentation,” and “This procedure is only reimbursed when billed with the appropriate base code.”
- Provider performed two primary procedures at C 5/6 & C 6/7 and reimbursed Claims Administrator.
- CPT 1997 “Report Only One Bone Graft Code Per Session.”
- CMS 1500 reflects place of service as “21” with 20936 reported before 20930.
- First reported code, 20936 will be utilized as the “one” reported code as per CPT.
- 20936 has a status indicator of “C” and is “not paid under OPPS.”
- Unable to recommend separate Physician Service payment for Status Indicator ‘C.’
- CPT 63076, cervical, **each additional** interspace, denied by Claims Administrator indicating the following: “The value of this service is included in the value of another service.
- CPT 1997 Reflects 63076 as an-add on code. Provider billed, and was reimbursed for, primary code.
- Two separate levels, C 5/6 & C 6/7 reflected on Operative Report.
- CPT 63076 is not subject to multiple procedure rule this is already calculated into the codes relative value.

- Reimbursement is warranted for CPT 63076.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 20930, 60376, & 20936

Date of Service: 11/06/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
20930	\$1100	\$ 0.00	\$ 117.35	N/A	N/A	\$0.00	Refer to Analysis
20936	\$1550	\$ 0.00	\$ 117.40	N/A	N/A	\$0.00	Refer to Analysis
63076	\$1950	\$ 0.00	\$745.65	N/A	N	\$706.40	PPO Contract

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