

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 10, 2014

██████████
██████████
██████████

IBR Case Number:	CB14-0000503	Date of Injury:	01/28/2013
Claim Number:	██████████	Application Received:	03/28/2014
Claims Administrator:	██████████	Assignment Date:	06/25/2014
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	20936 and 20930		

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 \$366.29 in additional reimbursement for a total of \$701.29. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$701.29 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,

██████████
Chief Coding Reviewer

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: PPO Contract
- National Correct Coding Initiatives
- Other: OMFS General Information and Instructions

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 codes 20936 & 20930.
- Claims Administrator denied codes indicating on the Explanation of Review “We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible. (Service must be billed with base code)” Other codes billed along with denied codes include: 22554, 63075, 22845, 64830, 22851 and 72020.
- Operative report was reviewed which details “C5-C6 anterior cervical discectomy, anterior cervical plate, placement of PEEK cage, anterior cervical fusion, local bone graft harvesting supplemented with decalcified Allograft bone with the use of operating microscope and serum fluoro imaging.” Further details include “Anterior and posterior osteophytes were taken down with Midas Rex and shaving saved with suction trap to be used as bone graft and use to cage along with some supplemental decalcified allograft bone...Some additional allograft bone was placed in either side of the cage to the space.”
- CPT codes 20936 & 20930 are both described as “List Separately” codes. Pursuant to OMFS General Information and Instructions, Add-on codes are exempt from the multiple procedure concept, rule number 7, and are reimbursed at 100% of their value. All add-on codes are exempt from the multiple procedure concepts. They are exempt from the use of Modifier -51 as these procedures are not reported as stand-alone codes. Add-on codes can be readily identified by specific descriptor nomenclature which includes phrases such as “each additional” or “List Separately in addition to primary procedure”.
- A PPO Contract was received and a 10% discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of codes 20936 and 20930 is warranted.

Date of Service: 10/24/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
20936	\$ 1550.00	\$ 0.00	\$ 121.88	N/A	Exempt	\$ 222.39	DISPUTED SERVICE: Allow reimbursement \$222.39
20930	\$ 1100.00	\$ 0.00	\$ 121.87	N/A	Exempt	\$ 143.90	DISPUTED SERVICE: Allow reimbursement \$143.90

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