

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 5, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000521	Date of Injury:	04/20/2012
Claim Number:	[Redacted]	Application Received:	04/02/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22845 & 63075-51		

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.

IBR Case Assigned: 06/09/2014

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 \$2394.64 in additional reimbursement for a total of \$2644.64. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2644.64 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: PPO Contract(Paid at 100% OMFS or billed charges, whichever is less)
- National Correct Coding Initiatives
- Other: OMFS General Information and Instructions(8 CCR §9789.11(a)(1)), AMA CPT 1997 & 2013,

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 the reimbursement of CPT codes 22845 & 63075-51.
- 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
- Claims Administrator reimbursed CPT codes 22845 & 63075-51 with Explanation of Review indicating: "Allowance for this service is made at 25% of the Global Surgery Fee as per multiple surgery rule of the Official Medical Fee Schedule."
- Procedure code 22845 is described "Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)."
- Pursuant OMFS Guidelines for surgery; " All add-on codes found in CPT are exempt from the multiple procedure concept, rule number 7, and are reimbursed at 100% of their value. Add-on codes in CPT can be readily identified by specific descriptor nomenclature

which includes phrases such as “each additional” or “(list separately in addition to primary procedure)”, therefore, CPT 22845 should be paid at 100% Official Medical Fee Schedule.

- CPT code 63075-51 is described as “Discectomy, anterior, with decompression of spinal cord and/or nerve roots(s), including osteophyctomy; cervical, single interspace” with Modifier 51 for Multiple Procedures. Pursuant the surgical guidelines: “Reimbursement for multiple surgical procedures performed at the same session is calculated as follows: Major (highest valued) procedure: 100% of listed value; second (second highest valued or equivalent) procedure: 50% of listed value”. CPT 63075-51 should have been reimbursed at 50% and therefore additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on OMFS guidelines for reimbursement, additional reimbursement is warranted for CPT codes 22845 & 63075-51.

Date of Service: 7/12/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery Reduction	Workers' Comp Allowed Amt.	Notes
22845	\$2650.00	\$628.64	\$1885.92	Percent reduction 0%	\$2514.56	DISPUTED SERVICE: Allow reimbursement of \$1885.92
63075-51	\$3290.00	\$508.73	\$508.73	Percent reduction 50%	\$1017.45	DISPUTED SERVICE: Allow reimbursement of \$508.72

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