

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 24, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000563	Date of Injury:	12/08/2011
Claim Number:	[REDACTED]	Application Received:	04/11/2014
Claims Administrator:	[REDACTED]	Assignment Date:	06/24/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22851		

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 \$784.89 in additional reimbursement for a total of \$1034.89. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1034.89 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]

Medical Director

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: None received
- National Correct Coding Initiatives
- Other: OMFS Physician Services

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 code 22851.
- Claims Administrator denied code indicating “The Official Medical Fee Schedule does not list this code. No payment is being made at this time.”
- 22851 - Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure).
- Operative report submitted describes biomechanical devices inserted at C4-C5, C5-C6 and C6-C7.
- All add-on codes found in CPT are exempt from the multiple procedure concept rule #7 and are reimbursed at 100% of their value. They should not be considered the primary procedure for purposes of the surgical cascade. All add-on codes found in CPT are exempt from the multiple procedure concepts and can be identified as “List separately in addition to primary procedure”.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code 28851 is warranted.

Date of Service: 5/20/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22851	\$784.89	\$0.00	\$784.89	N/A	100%	\$ 784.89	DISPUTED SERVICE: Allow reimbursement \$784.89.

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