

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 16, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001183	Date of Injury:	12/15/2010
Claim Number:	[Redacted]	Application Received:	08/21/2014
Claims Administrator:	[Redacted]		
Assigned Date:	11/13/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22612-22, 22842-22 x 4 units, 22851-22 x 2 units, 22325-22, 22852-99-22-59 (5 units), 22849-99-22-59 (4 units)		

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 \$1264.98 in additional reimbursement for a total of \$1514.98. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1514.98 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: PPO Contract Discount 5%
- National Correct Coding Initiatives
- Medically Unlikely Edits

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 reimbursement of codes 22612-22, 22842-22 x 4, 22851-22 x 2, 22325-22, 22852-99-22-59 (5 units), 22849-99-22-59 (4 units)
- According to CMS Medically Unlikely Edits, codes 22842 and 22851 show a value of one (1) for physicians. The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. Therefore, additional reimbursement for units is not warranted. Code 22852 was denied by claims administrator and does not appear on approved authorization from Utilization Review Unit. Therefore, code 22852 does not warrant reimbursement.
- Claims administrator reimbursed a partial payment which did not include the additional reimbursement of modifier -22 for which provider appended to every code in dispute.
- Based on review of the operative report by our medical director, it was found: “On this case Modifier 22 is not warranted by the documentation in all parts of the bill. The explanation statement says the operative time was extended, but operative time alone is not a criteria and the op note does not list start or end time. The blood loss was not extensive. Pedicle sclerosis is not rare and the amount of dissection for a one level scoliosis is not demanding. Since a pedicle screw was aborted, then less instrumentation was used. Billing for 80 instances suggests a typo and adding modifier 22 for a diagnostic

test suggests error. Since the surgeon had difficulty with pedicle screw insertion, it seems reasonable to allow a modifier 22 for that part of the operation, but not the rest.”

- Therefore, additional reimbursed for code 22849-22 is warranted only.
- Maximus requested a copy of the PPO contract which the Explanation of Review showed a reduction. Provider submitted documentation stating they do not have a contract. Claims administrator submitted a copy of the contract signed by the physician showing a discount of 5% is to be applied to reimbursement. Calculations on the reimbursed codes were paid according to the OMFS less 5% PPO discount.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 22849-22 is recommended.

Date of Service: 3/4/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22612	\$3263.31	\$2480.12	\$130.53	1	N/A	\$ 0.00	DISPUTED SERVICE: No reimbursement recommended.
22842	\$5083.00	\$1173.29	\$61.75	3	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
22851	\$2490.00	\$626.62	\$32.98	2	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
22325	\$4862.00	\$1121.28	\$59.01	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
22852	\$17265.00	\$0.00.	\$7147.63	5	NA/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
22849	\$14808.00	\$5060.08	\$5592.67	4	100%	\$6325.06	DISPUTED SERVICE: Allow reimbursement \$1264.98

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