

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 15, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001512	Date of Injury:	04/12/2011
Claim Number:	[Redacted]	Application Received:	10/09/2014
Claims Administrator:	[Redacted]		
Assigned Date:	11/10/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22585-99-22-80, 63075-99-22-80, 63076-99-22-80, 22855-99-22-80, 22849-99-22-80, 22851-99-22-80, 22851-99-22-59-80, 22845-99-22-80, 22110-99-22-59-80, 76001-99-22-80 and 64830-99-22-80.		

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 \$1974.84 in additional reimbursement for a total of \$2224.84. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2224.84 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:
- National Correct Coding Initiatives

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 22585-99-22-80, 63075-99-22-80, 63076-99-22-80, 22855-99-22-80, 22849-99-22-80, 22851-99-22-80, 22851-99-22-59-80, 22845-99-22-80, 22110-99-22-59-80, 76001-99-22-80 and 64830-99-22-80.
- 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.
- Based on review of the operative report, Provider has documented all procedures performed on date of service 11/05/2013 along with a separate report for the fluoroscopy and modifier -22.
- The operative report was reviewed by the Maximus Medical Director who concluded "In this anterior cervical discectomy and fusion, it seems reasonable to allow modifier 22's use for the discectomy, arthrodesis and anterior plate placement due to fact the patient weighed 300 lbs. making spine visualization difficult and the C-arm fluoro unit had to be used."
- Based on information reviewed, additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 22585-99-22-80, 63075-99-22-80, 63076-99-22-80, 22855-99-22-80, 22851-99-22-80, 22851-99-22-59-80, 22845-99-22-80, 22110-99-22-59-80, 76001-99-22-80 and 64830-99-22-80 is recommended.

Date of Service: 11/05/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22110	\$53.60	\$22.57	\$31.03	Yes	25%	\$53.60	DISPUTED SERVICE: Allow reimbursement \$31.03
22851	\$196.22	\$156.98	\$39.24	Yes	100%	\$196.22	DISPUTED SERVICE: Allow reimbursement \$39.24
64830	\$254.36	\$0.00	\$254.36	Yes	50%	\$254.36	DISPUTED SERVICE: Allow reimbursement \$254.36
22845	\$628.64	\$0.00	\$628.54	Yes	100%	\$628.64	DISPUTED SERVICE: Allow reimbursement \$628.64
22855	\$446.95	\$0.00	\$446.95	Yes	25%	\$111.74	DISPUTED SERVICE: Allow reimbursement \$111.74
22849	\$341.57	\$273.26	\$68.31	Yes	25%	\$170.78	DISPUTED SERVICE: Not a standalone code. No reimbursement recommended.
76001	\$432.25	\$0.00	\$432.25	Yes	N/A	\$432.25	DISPUTED SERVICE: Allow reimbursement \$432.25
22585	\$152.62	\$125.62	\$27.00	Yes	100%	\$152.62	DISPUTED SERVICE: Allow reimbursement \$27.00
63076	\$196.22	\$0.00	\$196.22	Yes	100%	\$196.22	DISPUTED SERVICE: Allow reimbursement \$196.22
63075	\$254.36	\$0.00	\$254.36	Yes	50%	\$254.36	DISPUTED SERVICE: Allow reimbursement \$254.36

Copy to:

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