

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 27, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001616	Date of Injury:	04/01/2010
Claim Number:	[REDACTED]	Application Received:	10/27/2014
Claims Administrator:	[REDACTED]	Assignment Date:	11/24/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63020-80, 63035-80 and 22830-59-80		

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 \$439.24 in additional reimbursement for a total of \$689.24. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$689.24 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]
[REDACTED]

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

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 seeking full remuneration for Assistant Surgical Provider Services 63020-80, 63035-80, & 22830-59-80, performed on 07/15/2014.**
- Claims Administrator reimbursement rationale: “Workers Compensation Fee Schedule Adjustment.”
- Services not in dispute.
- Reimbursement calculations are in dispute.
- Provider submitted “already reduced” charges as per statement on IBR request.
- The CPT Codes in question will be defined utilizing the American Medical Association Current Procedural Code Book, 2014:

CPT 82145: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical.

CPT 63035: Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure).

CPT 22830: Exploration of spinal fusion.

- **§9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Practitioner Services – For Services Rendered On or After January 1, 2014. §9789.16.8 Surgery:** “Assistants-at-Surgery For assistant-at-surgery services performed by physicians, the fee schedule amount equals **16 percent** of the amount otherwise applicable for the surgical payment. Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the

AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy.”

- Modifier -80 reflected on CMS 1500
- Provider’s submitted charges reflect 20% reduction.
- Claims Administrator’s reimbursement appears to be reimbursed @ 20 % reduction x 2 for each code.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement for codes 63020-890, 63035-80 and 22830-59-80 is warranted.

Date of Service: 07/15/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
63020	\$382.00	\$61.12	\$304.84	Y	1	\$290.18	16% Assistant Surgeon - PPO Contract – Reimbursed Amount = \$290.18 Due Provider
63035	\$310.78	\$9.60	\$58.77	Y	1	\$47.24	16% Assistant Surgeon - PPO Contract – Reimbursed Amount = \$47.24 Due Provider
22830	\$268.00	\$21.44	\$234.23	Y	1	\$101.82	16% Assistant Surgeon – 50% MPPR - PPO Contract – Reimbursed Amount = \$101.82 Due Provider

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