

**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 20, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0001669	Date of Injury:	08/17/2010
Claim Number:	[Redacted]	Application Received:	11/03/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	08/22/2014 – 08/22/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63047-62-59, 63048-62-59, 22214-62-51, 22216-62, 22842-62, 22851-62, 22612-62-51		

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.

**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 \$2032.39 in additional reimbursement for a total of \$2282.39. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2282.39 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 2%
- 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 63047-62-59, 63048-62-59, 22214-62-51, 22216-62, 22842-62, 22851-62, 22612-62-51
- Claims administrator reimbursed a partial payment indicating on the Explanation of Review “The charges have been priced in accordance to a PPO contract.”
- Provider billed codes with modifier -62 for co-surgeons. Documentation was reviewed stating the two surgeons each receive 50% of the allowable charges. The fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Codes are also subject to the multiple procedure reduction reimbursement.
- Codes 63048, 22216, 22842, 22851 are all listed separately, codes which are to be reimbursed at 100% of OMFS less the PPO discount of 2%.
- Code 22612 has the highest relative value and is reimbursed at 100% less the 2% discount. Codes 22214 and 63047 are both reimbursed at 50% per multiple procedure reduction reimbursement. CPT 63047 was denied in full with claims administrator stating it was included in another procedure billed on the same day. However, 63047 was billed with modifier -59 and is documented in the provider’s report which per NCCI regulations may override the CCI edit and therefore reimbursement is warranted.
- Based on information reviewed, additional reimbursement on codes is warranted.

- PPO contract reviewed shows a 2% discount is to be applied.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 63047-62-59, 63048-62-59, 22214-62-51, 22216-62, 22842-62, 22851-62 and 22612-62-51 is warranted.**

Date of Service: 8/22/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Co-Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
22612	\$1631.66	\$1019.79	\$611.87	Yes	100%	\$1599.03	<b>DISPUTED SERVICE:</b> Allow reimbursement \$579.24
22214	\$1528.78	\$477.74	\$286.65	Yes	50%	\$749.10	<b>DISPUTED SERVICE:</b> Allow reimbursement \$271.36
63047	\$1130.84	\$0.00	\$1130.84	Yes	50%	\$554.11	<b>DISPUTED SERVICE:</b> Allow reimbursement \$554.11
63048	\$214.73	\$134.21	\$80.52	Yes	100%	\$210.44	<b>DISPUTED SERVICE:</b> Allow reimbursement \$76.23
22216	\$369.26	\$230.79	\$138.47	Yes	100%	\$361.87	<b>DISPUTED SERVICE:</b> Allow reimbursement \$131.08
22842	\$771.90	\$482.44	\$289.46	Yes	100%	\$756.46	<b>DISPUTED SERVICE:</b> Allow reimbursement \$274.02
22851	\$412.25	\$257.66	\$154.59	Yes	10%	\$404.01	<b>DISPUTED SERVICE:</b> Allow reimbursement \$146.35

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