

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 20, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0001930	Date of Injury:	04/29/2014
Claim Number:	[Redacted]	Application Received:	12/15/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/20/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63081-62, 63082-62 (2 units), 22554-51-62, 22585-62, 22845-62, 22851-62 (2 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 \$1734.26 in additional reimbursement for a total of \$1984.26. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1984.26 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,

Paul Manchester, MD, MPH  
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 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 63081-62, 63082-62 (2 units), 22554-51-62, 22585-62, 22845-62, 22851-62 (2 units)
- Provider billed codes on a CMS 1500 form with billed amounts already reduced per modifier -62 rule: Per the Official Medical Fee Schedule Surgery General Information and Ground Rules 14 (d), two surgeons: under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical problem. By prior agreement, the total value may be apportioned in relation to the responsibility and work done, provided the payer is aware of the fee distribution according to medical ethics. The total value shall be increased by 25% in lieu of the assistant's charge.
- The operative report indicated the co-surgeons both agreed to apportion of the total surgical fees of 50% to each co-surgeon.
- Claims administrator reduced the already reduced billed charges by another 62.5% which is incorrect reimbursement for the OMFS co-surgeon rule.
- CPT code 22554-62 is subject to the multiple procedure reduction rule and is reimbursed at 50% of allowed OMFS as it is the secondary procedure as 63081-62 is the primary procedure reimbursed at 100%. All the other codes billed are List Separately codes and reimbursed at 100% OMFS as they are not subject to multiple reduction.
- PPO contract received shows a 2% discount is to be applied to reimbursement.

