MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 11, 2015

[redacted]

IBR Case Number:	CB15-0000190	**Date of Injury:**	01/17/1999
Claim Number:	[redacted]	**Application Received:**	02/06/2015
Claims Administrator:	[redacted]	**Assignment Date:**	02/20/2015
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	63047-62-22 & 63048-62-22 x 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 $195.00 for the review cost and $1,949.77 in additional reimbursement for a total of $2,144.77. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $2,144.77 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, M.D., M.P.H.
Medical Director

Cc: [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
- NCCI Edits
- 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 additional remuneration for Co-Surgeon Services relating to 63047-62-22 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar & add-on code 63048-62-22 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure) x 2 Units, performed on 08/29/2014.**
- Claims Administrator denied services based on the following rational for 63047-62-22: "Per CPT, the code is reported with another service that would be medically improbable and contradictory in nature."
- CPT 63048 was denied due to parent code, 63047 denial.
- **§9789.12.13** Correct Coding Initiative (a) The National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment.
- EOR Reflects

- **NCCI Edit Table -** Physician Version 20.2 (7/1/2014-9/30/2014). Procedures 22852 & 63707 are reflected on CMS 1500 and are presented in the Active CCI Edit Table below. The following code pairs generally cannot be reported together.
  If Modifier Indicator = 1 , there may be occasions where both codes are payable, if the appropriate modifier is applied. CMS1500 for date of service 08/29/2014 does not reflect the appropriate modifier applied to unbundle the following code pairs relating to 63047:

Column 1	Column 2	CCI Edit Description	Modifier Indicator	Effective Date	Termination Date
		short description for column 2 code			
		REMOVE SPINE LAMINA 1 LMBR			
63047	22852	Standards of medical / surgical practice	1	1/1/1996	-
		REMOVE SPINE FIXATION DEVICE			
63047	63707	Standards of medical / surgical practice	1	1/1/1996	-

- **CPT 63707** Code Description: Repair of dural/cerebrospinal fluid leak, **not requiring laminectomy.**
- Operative report indicates the following:
  - 63047 & 63048 **performed at L1 & L2.**
  - 63707 **performed at T12**
- It appears the Claims Administrator denied 63047 and add-on Code 63048 due to 63707. However, the operative report indicates procedure 63707 was not performed at L1 & L2; 63707 was performed in the thoracic area of T12.
- Based on the aforementioned documentation and guidelines, additional reimbursement is supported for 63047 & 63048 x 2.
- Physician Reviewer reviewed operative report for Modifier -22 and stated the surgery "does qualify for -22 modifier."
- Co-surgeon Agreement reflected in Operative Report, Page 2, Paragraph 6.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 63047-62-22 & 63048-62-22 x 2 units

Date of Service: 08/29/2014
Provider Services

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
63047	$1,413.55	$0.00	$1,413.55	1	$1,413.55	**Refer to Analysis**
63048	$536.22	$0.00	$536.22	2	$536.22	**Refer to Analysis**
22852	N/A	N/A	N/A	N/A	N/A	**Not in Dispute**
63707	N/A	N/A	N/A	N/A	N/A	**Not in Dispute**

Copy to:

[redacted]

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