

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 24, 2015

██████████
██████████
██████████

IBR Case Number:	CB15-0002197	Date of Injury:	09/24/2013
Claim Number:	██████████	Application Received:	11/30/2015
Assignment Date:	12/18/2015		
Claims Administrator:	██████████		
Date(s) of service:	04/30/2015 – 04/30/2015		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	22899, 64999, and 64999-59		

Dear ██████████

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 \$3,068.00 in additional reimbursement for a total of \$3,236.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$3,263.00** 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: ██████████
██

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
- AMA CPT
- NCCI Edits
- Contractual Agreement
- OMFS

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 remuneration for Unlisted Procedure Codes 22899, 64999 and 64999-59 for date of service 04/30/2015.**
- The Claims Administrator denied services as “included in the value of another service performed on the same day.”
- Operative report documents anterior vertebral decompression of the cauda equina and reduction in addition to reported primary procedure.
- 64999 is an unlisted code.
- **CCR § 9789.12.4.** “By Report” - Reimbursement for Unlisted Procedures/Procedures Lacking RBRVUs. (c) In determining the value of a By Report procedure, consideration may be given to the value assigned to a comparable procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed.
- **CPT 63090** Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment and **add-on code 63091** (each additional) are comparable cross walks for reported procedures 64999 and 64999-59.
- Opportunity to Dispute communicated to Claims Administrator on 12/22/2015 response not yet received.
- Submitted Contractual Agreement indicates “92% OMFS.
- Modifier – 59, Distinct Procedural Service, appropriately appended.
- Unlisted CPT 22899 representing “reducing of spondylolisthesis” is included in the value of the main procedure performed (and reimbursed) on the same day.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 63090 and 63091 – reported as 64999 and 64999-59; Reimbursement in not indicated for 22899.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 64999, 64999-59 and 22899

Date of Service: 04/30/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
64999-59	\$4,500.00	\$0.00	\$4,500.00	1	\$2,813.33	Reimburse as 63090-59
64999	\$4,300.00	\$0.00	\$4,300.00	1	\$254.67	Reimburse as add-on code 63091
22899	\$6,628.00	\$0.00	\$6,628.00	1	\$0.00	Refer to Analysis

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