

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 30, 2015

[REDACTED]

IBR Case Number:	CB15-0002212	Date of Injury:	09/28/2014
Claim Number:	[REDACTED]	Application Received:	11/30/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/27/2015 – 08/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63081 and 63082		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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]

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
- National Correct Coding Initiatives
- Other: OMFS Physician's 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 is disputing the denial of CPT 63081 and 63082.
- The Claims Administrator denied the two CPT codes with the following rationale: The documentation does not support the level of service billed. The billed procedure does not meet the minimum requirements as listed in the fee schedule.
- In addition to the disputed codes the Provider billed the following CPT codes: 22554-59; 22845; 22851; 20936; and 69990.
- The Operative Report documented the following Procedures as performed: C5-C6 anterior cervical discectomy, anterior cervical fusion, placement of PEEK cage, anterior cervical plate, partial corpectomy, C5-C6, use of locally harvested bone graft, operating microscope and C-arm fluoro imaging.
- CPT 63081: Vertebral **corpectomy** (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
- In order for the procedure to be reported as a corpectomy, half of the vertebral body must be resected.
- CPT 63082: Vertebral **corpectomy** (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)

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- In order for the procedure to be reported as a **corpectomy**, half of the vertebral body must be resected.
- The Operative Report did not document the how much of the vertebral body was removed. The Procedure Detail section of the report indicated “posterior aspect of the vertebral bodies were taken down to enlarge the working space.” The description “partial” or “taken down” does not provide detail documentation as to how much, or what portion of the vertebral body was removed.
- The medical record did not substantiate the billed codes 63081 and 63082. Reimbursement is not recommended for CPT 63081 or 63082.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 63081 and 63082.

Date of Service 8/27/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63081	\$7010.00	\$0.00	\$7010.00	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
63082	\$ 2337.00	\$ 0.00	\$ 2337.00	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.

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