

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 12, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001085	Date of Injury:	03/15/1988
Claim Number:	[Redacted]	Application Received:	07/06/2015
Assignment Date:	07/24/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	04/07/2014 – 04/07/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	22558-22-62, 63090-22-59, 22851x 2, 22845-22-59, 22325-22-59,		

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 \$5,453.79 in additional reimbursement for a total of \$5,648.79. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$5,648.79** 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]
[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
- CPT 2014

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 22558-22-62 Total disc arthroplasty (artificial disc), anterior approach, 63090-22-59 Remove Vert Body, 22851x 2 Application of intervertebral biomechanical device, 22845-22-59 Anterior instrumentation; 2 to 3 vertebral segment , 22325-22-59 Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar, & 72100 Radiologic examination, spine, lumbosacral; 2 or 3 views , 26-22 x 80 performed on 04/07/2014.**
- The Claims Administrator denied claim based on “documentation” and “duplicate charges.”
- Documentation reviewed by Physician Review for Modifier 22 and 72100; “The operative note does not validate the presence of difficulty or complexity beyond what is normally encountered. As to billing for 80 views and 3 hours of fluoroscopy this would present the patient with an enormous radiation exposure. There is no time log of time of onset or duration of each view to add up to 80 views and 3 hours. The blood loss was fortunately only a few teaspoonfuls. There is no description about why the buttress screw was so difficult or BMP insertion complex.”
- 72100 x 80 films and/or interpretation/reports not included in IBR.
- Medically Unlikely Edits indicate 1 unit for 72100.
- Reimbursement for Modifier -22 and 72100 is not indicated.
- Documentation reflects procedures performed at two different levels with 2 different devices; L4-L5 and L5-S1. Reimbursement is warranted for these separate levels. Reimbursement is warranted for 22851 x 2, 22845, 22325 & 63090.
- CMS 1500 Form indicates 22558 billed as two line items.
- EORs indicate one 22558 line item paid in accordance with Modifier 62 and Modifier 22.
- The Medically Unlikely Edits indicate procedure 22558 may only be reported once during an operative session. CPT 2014 indicates add-on code 22585 to be utilized for multiple levels in addition to Parent Code 22558. Additional Reimbursement is not indicated for 22558-22-62.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, the table below reflects reimbursement for 22558-22-62, 63090-22-59, 22851x 2, 22845-22-59, 22325-22-59, 72100, 26-22 x 80

Date of Service: 04/07/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
22558 - 99-22-62	\$7,212.50	\$0.00	\$1,578.94	1	\$0.00	Refer to Analysis
63090 - 99-22-59	\$4,625.00	\$0.00	\$2,016.80	1	\$2,016.80	\$2,016.80 Due Provider Refer to Analysis

22851	\$3,112.50	\$0.00	\$824.50	1	\$659.60	\$659.60 Due Provider Refer to Analysis
22851	\$3,112.50	\$0.00	\$824.50	1	\$659.60	\$659.60 Due Provider Refer to Analysis
22845 – 99-22-59	\$8,620.00	\$0.00	\$1183.35	1	\$1,183.35	Refer to Analysis
22325 – 99-22-59	\$6,077.50	\$0.00	\$1,180.29	1	\$1,180.29	\$1,180.29 Due Provider Refer to Analysis
72100	\$8,800.00	\$61.02	\$1013.98	80	\$61.02	Refer to Analysis

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