

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 16, 2016

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000786	Date of Injury:	01/14/2015
Claim Number:	[Redacted]	Application Received:	05/11/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	12/04/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63047-62-59, 63048, 22214, 22216, 22842, 22851, 22630 & 22612		

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 \$2310.59 in additional reimbursement for a total of \$2505.59. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2505.59 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,

MAXIMUS

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
- National Correct Coding Initiatives
- Other: OMFS Physicians 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 seeking additional reimbursement for codes 63047-62-59, 63048, 22214, 22216, 22842, 22851, 22630 & 22612 performed on date of service 12/04/2015**
- Provider billed codes along with 22612 on a CMS 1500 with Place of Service ‘21’
- Claims Administrator
- Provider’s Operative Report documents “Procedure: 1. Bilateral laminectomy, facetectomy, and foraminotomy (CPT 63047-59); 2. Bilateral partial laminectomy L2 (CPT 63048-59); 3. Complete excision of the intervertebral disc at L2-3(CPT 22851); 4. Interbody fusion; 5. Bilateral posterior osteotomy of the L2 vertebral body (CPT 22214-59); 6. Bilateral posterior osteotomy of the L3 vertebral body (CPT 22216-59)”
- Page 2 of Provider’s report documents co-surgeons during this procedure and they “agreed to apportion the total surgical fees 50% to each co-surgeon”
- Modifiers -62 and -59 was appended to codes.
- As 22612 is the main procedure, CPT codes 63047, 22214 and 22630 are subject to multiple procedure reduction.
- PPO contract not submitted for review.
- Based on calculations for co-surgeon, additional reimbursement is indicated for codes 63047-62-59, 63048, 22214, 22216, 22842, 22851, 22630 & 22612.

The table below describes the pertinent claim line information.

