

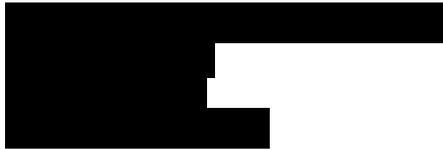
MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 7, 2016



IBR Case Number:	CB16-0000872	Date of Injury:	07/10/1991
Claim Number:	[REDACTED]	Application Received:	05/25/2016
Claims Administrator:	[REDACTED]		
Assigned Date:	6/24/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22845, 22851, 22851-59, and 22552		

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 \$619.14 in additional reimbursement for a total of \$814.14 A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$814.14 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]

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 22845, 22851, 22851-59 and 22552.**
- Provider billed codes along with 22551 on a CMS 1500 with Place of Service '21'
- Claims Administrator denied 22845, 22851, 22851-59, 22552 with indication "Number of services exceeds utilization agreement."
- The DWC Form RFA listed the Service Good Requested as "Anterior Cervical Discectomy and Fusion C3-4-5, Removal of Anterior Instrumentation Inpatient 1-2 days." Section/Notes from Certifier at the bottom of the RFA stated "Specific Request: Anterior Cervical Discectomy and Fusion C3-4-5, Removal of Anterior Instrumentation Inpatient 1-2 days. Approved by physician advisor 8/24/15."
- Based on the above mentioned Authorized RFA, and Operative Report, the documentation substantiated the reimbursement of CPT 22552. Operative report documented anterior cervical discectomies were performed at both C3-C4 and C4-C5.
- The codes 22845, 22851 and 22851-59 were listed in the section CPT/HCPCS Code section if the RFA. However, these services were not included in the "Service/Good Requested (Required)" section of the RFA. These codes are for the placement of the interbody fusion cages and interior instrumentation for C3-C4 and C4-C5.
- An additional Authorization letter was received and reviewed. The letter was dated 9/24/2015 from the Claims Administrator and stated the following: "Specific Request: Anterior Cervical Discectomy and Fusion C3-4-5, Removal of Anterior Instrumentation

Inpatient 1-2 days, Pre-op Clearance, Vista Cervical Collar ****Approved by physician advisor**.** Start/End date indicated as 8/18/2015-10/18/2015. The following statement was included in the authorization letter “This review applies only the specific service(s) listed. Additional services require separate review.” The statement was located in the Second to the last paragraph in the authorization letter dated 9/24/2015.

- In reviewing the RFA and Authorization it does not appear the codes 22845, 22851 and 22851-59 were authorized procedures.
- Reimbursement is not recommended for the disputed codes 22845, 22851 and 22851-59.
- Reimbursement recommended for CPT 22552.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes: 22552, 22845, 22851, 22851-59.

Date of Service 12/1/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
22552	\$1272.00	\$0.00	\$619.14	N/A	1	\$619.14	DISPUTED SERVICE- See analysis.
22845	\$6007.00	\$0.00	\$1134.53	N/A	1	\$0.00	DISPUTED SERVICE- See analysis
22851, 22851-59	\$3140.00	\$0.00	\$1264.94	N/A	2	\$0.00	DISPUTED SERVICE- See analysis

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