

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001956	Date of Injury:	06/25/2006
Claim Number:	[REDACTED]	Application Received:	12/22/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	01/28/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63042		

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]
[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

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 full remuneration for partial payment of 63042 Laminectomy Single Lumbar performed by Assistant at Surgery on 07/15/2014.**
- The Claims Administrator denied the service with the following rationale: “The charge exceeds the Official Medical Fee Schedule. The charge has been adjusted to the scheduled allowance.”
- Modifier AS: Assistant at Surgery
- §9789.15.1 (c) Non-Physician Practitioner (NPP) – Payment Methodology (c) When a NPP actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services, the NPP’s services are eligible for payment as assistant-at-surgery services. Maximum fees for covered NPP assistant-at-surgery services shall be 85 percent of what a physician is paid under the Official Medical Fee Schedule - Physician Fee Schedule. Since physicians are paid at 16 percent of the surgical payment amount for assistant-at-surgery services, the actual payment amount that NPPs receive for assistant-at-surgery services is **13.6 percent of the amount paid to physicians**. The AS modifier must be reported when billing NPP assistant-at-surgery services.
- CMS 1500 Reflects AS Modifier.
- §9789.16.5 (c) Multiple Surgeries and Endoscopies - Determining Maximum Payment for Multiple Surgeries - The Multiple Procedure (“Mult Proc”) column of the National Physician Fee Schedule Relative Value File contains a “2” to indicate procedures that are subject to the surgery multiple procedure payment reduction.

- CMS 1500 reflects 63042 is subject to MPPR reduction, with an indicator of “2” in the MPPR payment column of the Fee Schedule.
- EOR 12/01/2014 reflects \$289.85 reimbursement for CPT 63042 –AS, -59.
- Based on the aforementioned documentation and guidelines, The Claims Administrator applied the appropriate reductions to CPT 63042 –AS, -59 reimbursement is correct.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 63042 – AS - 59

Date of Service: 07/15/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63042	\$2,100.00	\$289.85	\$904.68	1	Y	\$289.85	Refer to Analysis

Copy to:

██████████
 ██████████
 ██████████

Copy to:

██
 ██
 ██