

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
- Negotiated contracted rates: N/A
- National Correct Coding Initiatives

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 remuneration for codes 63047-62-22, 63048-62-22, and 22830-62-59 performed on date of service 01/22/2016
- Provider billed codes along with 22612 on a CMS 1500 with Place of Service '21'
- Claims Administrator denied 22830 with indication "value of service is included within the value of another service performed on the same day"
- Provider's Operative Report documents "Procedure: 2. Exploration of posterolateral fusion L2 to L5; 3. Bilateral revision laminectomy L1; 4. Bilateral revision laminectomy L2; 5. Bilateral revision laminectomy L3; 7. Bilateral posterior intertransverse fusion at L1 to L4 (CPT 22612) & (CPT 22614 x 2)"
- Pursuant Medicare NCCI Policy Chapter IV: Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code **22830** describes exploration of a spinal fusion. **CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area.** However, **if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure**, CPT code 22830 may be reported separately with modifier 59.
- Reimbursement of 22830 is not warranted.

- Page 2 of Provider’s report documents cosurgeons during this procedure and they “agreed to apportion the total surgical fees 50% to each cosurgeon”
- Modifier -62 as well as modifier -22 (25% increase in service) were appended to codes 63047 and 63048.
- When submitting a claim with modifier 22, the physician should document what aspects of the procedure were above and beyond the typical. Some examples include morbid obesity, trauma, or extensive scarring.
- Page three of Operative Report documents “Additional operative time was necessary during a portion of this patient’s revision spinal procedure because of the scarring from the previous surgery. This created significant technical difficulty. Significant time was spent exposing and removing the previous posterior instrumentation and exploring the posterolateral fusion area...”
- Documentation supports modifier -22 for increase service value of 25%.
- CPT 63047 is not subject to multiple procedure reduction with modifier -22.
- 63047 has a 2016 RBRVS of \$1613.45.
 - $1613.45 \times 125\% = 2016.81 / 2$ (cosurgeon) = $1008.41 + 25\% = 1260.51$
- 63048 has a 2016 RBRVS of \$305.58, and is not subject to MPPR.
 - $305.58 \times 125\% = 381.98 / 2$ (cosurgeon) = $190.99 + 25\% = 238.74 \times 2$ units = 477.48.
- PPO contract not submitted for review.
- Based on calculations with increased service value, additional reimbursement is indicated for 63047 and 63048 x 2 units.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 63047-62-22, 63048-62-22, and 22830-62-59

Date of Service: 01/22/2016							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
63047	\$1413.55	\$504.21	\$1413.55	Yes	No	\$1260.51	\$756.30 Due to Provider
63048 x 2 units	\$536.82	\$381.98	\$536.82	Yes	No	\$477.48	\$95.50 Due to Provider

[REDACTED]

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