

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 29, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000130	Date of Injury:	06/10/2009
Claim Number:	[REDACTED]	Application Received:	01/30/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	2/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63012-59 and 63047-59		

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 \$904.68 in additional reimbursement for a total of \$1099.68. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1099.68 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, 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
- National Correct Coding Initiatives
- Other: AMA CPT Assistant

## 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 dissatisfied with denial of codes 63012-59 and 63047-59 for date of service 4/7/2014.
- Claims Administrator denied both codes indicating on the Explanation of Review “National Correct Coding Initiative Edit – either mutually exclusive of or integral to another service performed on the same day”; “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated” and “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- Based on NCCI Edits that exist between billed codes 22633 and 63047 and 63012, generally these codes are not billed together. However, Modifier Indicator column shows ‘1’ which states that if an appropriate modifier is appended to the correct CPT code and documentation supports the use of the code billed, then the Edit may be overridden.
- Provider’s Operative Report does show that both denied procedure codes were supported in his documentation and both codes were billed with an approved NCCI modifier -59. However, according to AMA CPT Assistant, when a posterior interbody technique is used in removing the disk and/or bony endplate **solely with the need** to prepare the vertebrae for fusion; then no additional 63000 series code(s) is reported. The appropriate 63045-63048, 63075-63078 code(s) should be reported, when in addition to removing the disk and preparing the vertebral endplate, the surgeon removes posterior osteophytes and

decompresses the spinal cord or nerve root(s), which requires work in excess of that normally performed when doing a posterior lumbar interbody fusion (PLIF).

- Based on AMA Guidelines, Provider's Operative Report does not support the use of code 63012 and therefore reimbursement of code 63012 is not warranted.
- Based on AMA Guidelines, Provider's Operative Report does document support of code 63047-59 and therefore, reimbursement of this code is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 63047-59 is recommended.

Date of Service: 4/7/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63012-59	\$6300.00	\$0.00	\$972.49	N/A	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement is recommended.
63047-59	\$7000.00	\$0.00	\$904.68	N/A	50%	\$904.68	<b>DISPUTED SERVICE:</b> Allow reimbursement \$904.68

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier Allowed?
Physician Version Number: 20.1	22630	63012	Yes
Physician Version Number: 20.1	22630	63047	Yes

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