

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 8, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000430	Date of Injury:	12/09/2008
Claim Number:	[REDACTED]	Application Received:	03/15/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63650 x 2		

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

[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
- Negotiated contracted rates: 90% PPO Reimbursement
- 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 seeking remuneration of billed code 63650 x 2 units on date of service 11/23/2015
- Claims Administrator's reimbursement rationale indicates "This charge was adjusted to comply with the rate and rules of the contract indicated."
- Provider states they were reimbursed for only 1 unit of 63650.
- A copy of the contract was not received for this review.
- Provider billed codes on a CMS 1500 with place of service '24'.
- The percutaneous implantation of neurostimulator electrodes code 63650 represents implantation of a single lead. Per coding guidelines, procedure code 63650 can be separately reported for placement of any additional electrode catheter(s) or plate(s)/paddle(s) by appending either modifier 51 (same anatomic site) or modifier 59 (different anatomic site) to the appropriate code. An array is a collection of electrical contacts on a single catheter, plate, or paddle. All neurostimulator electrode arrays have leads with multiple contact electrodes. Using present CPT coding convention, in spinal cord stimulation (63650) as an example, reporting is based on the number of electrode catheter, electrode plate, or electrode paddle "arrays" inserted.
- Procedure Note documents service performed on date of service.

- EOR reflects a PPO discount was applied to reimbursement of 63650. **Provider is not denying a contract agreement between the two parties.**
- **§9789.16.5. Surgery - Multiple Surgeries and Endoscopies. 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.**
- 63650 has a Multiple Procedure value of ‘2’.
- Pursuant Physician Fee Schedule CA Facility Allowable, 63650 1 unit \$654.54 + 2nd unit MPPR \$327.27 = \$981.81 * 90% = \$883.63
- § 9792.5.7 (b) unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code 5307.11 shall be resolved before seeking independent bill review.
- Based on aforementioned documentation and guidelines, additional reimbursement of 63650 x 2 units is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 63650 x 2 units

Date of Service: 11/23/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Procedure	Workers’ Comp Allowed Amt.	Notes
63650	\$5600.00	\$883.63	\$319.91	2	Yes	\$883.63	Refer to Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]