

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

5/2/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000221	Date of Injury:	10/1/2005
Claim Number:	[REDACTED]	Application Received:	7/3/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	1/10/2013 – 1/10/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63685, 63650 and 63650 Modifier 59		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/8/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$17,581.32, for a total of \$17,916.32.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the decision:

- 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 or negotiated contract: OMFS
- Other: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 1/10/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to an implantation of a spinal cord stimulator. The Claims Administrator allowed reimbursement of \$4,136.00 for CPT 63685 and 63650. The Claims Administrator denied reimbursement for CPT 63650 Modifier 59 with the explanation "The item or service billed has been packaged into the APC rate; therefore, no additional payment is allowed per California State Regulations." The Claims Administrator denied reimbursement on HCPCS L8681 and L8689 with the explanation "The item or service billed has been packaged into the APC rate; therefore, no additional payment is allowed per California State Regulations."

The Provider submitted a corrected claim, replacing the billed HCPCS L8681 and L8689 with L8687 and L8680. The Claims Administrator denied the billed HCPCS L8687 and L8680 on the explanation of review in response to the appeal with the explanation "The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed."

CPT 63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

CPT 63650 - Percutaneous implantation of neurostimulator electrode array, epidural

HCPCS L8687 - Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension

HCPCS L8680 - Implantable neurostimulator electrode, each

Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The billed CPT codes 63685 and 63650 have an assigned indicator of "S". The "S" indicator definition is "Significant procedure, Not Discounted When Multiple and qualifies for separate APC payment." The billed HCPCS L8680 and L8687 have an assigned indicator of "N". The "N" indicator definition is "Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment."

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. The operative report documented a "Dual lead percutaneous octet dorsal column stimulators implanted as well as pulse generator implant." The leads were placed in the posterior aspect at T7-8; one slightly left of the midline; and second slightly right of the midline. Reimbursement is warranted for both of the billed procedure codes 63650 and 63650 Modifier 59.

The implants billed as HCPCS L8680 and L8687 have an assigned status indicator of "N". A supply, drug or device with an assigned status indicator of "N" is packaged into the APC payment rate for services and does not warrant separate reimbursement.

MAXIMUS requested a copy of the PPO Contract. The PPO Contract was submitted; however, the contract did not appear to be complete. Based on a review of the explanation of review (EOR), it does not appear the ambulatory surgery services were reimbursed based on the submitted PPO contract or OMFS Hospital Outpatient Fee Schedule. The reviewers were unable to verify the correct PPO allowance based on the PPO contract submitted. Therefore, the Ambulatory Surgical Facility Service allowance was calculated based on the Official Medical Fee Schedule Hospital Outpatient Fee Schedule.

The additional reimbursement of \$17,581.32 is warranted per the Official Medical Fee Schedule Ambulatory Surgery Center services (63685, 63650 and 63650 Modifier 59).

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
63685		1	\$5,854.04	\$13,693.32	\$1,768.00	\$11,925.32	OMFS
63650		1	\$5,854.04	\$4,028.00	\$2,400.00	\$1,628.00	OMFS
63650	59	1	\$5,854.04	\$4,028.00	\$0.00	\$4,028.00	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 63685, 63650 and 63650 Modifier 59 (\$17,581.32) for a total of \$17,916.32.

The Claims Administrator is required to reimburse the provider \$17,916.32 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

██████████, RHIT

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