

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 7, 2014

[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|--------------|------------------------------|------------|
| IBR Case Number: | CB13-0000726 | Date of Injury: | 2/15/2006 |
| Claim Number: | [Redacted] | Application Received: | 11/12/2013 |
| Claims Administrator: | [Redacted] | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 63650-59 | | |

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 \$335.00 for the review cost and \$4184.40 in additional reimbursement for a total of \$4519.40. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$4519.40 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,

[Redacted]

Chief Coding Reviewer

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
- Negotiated contracted rates: no contract
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: CMS FAQ on Medically Unlikely Edits

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:** 63650–59 for a third neurostimulator was denied due to Medically Unlikely Edits (MUE).
- Based on the NCCI MUE file only two neurostimulators can be reviewed without question.
- Based on review of the operative report reimbursement is warranted for a third neurostimulaor. Therefore assignment of code 63650-59 is current.
- Per CMS FAQ’s on MUE’s an appropriate HCPCS/Current Procedural Terminology (CPT) modifier can be used to report the same code on separate lines of a claim to enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value. In this case the provider used modifier 59 which is correct.
- This procedure was pre-approved by the Claims Administrator on 4/19/13 for 4 neurostimulators.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 63650-59 is appropriate.

| Date of Service: 6/19/2013 | | | | | | |
|-----------------------------------|------------------------|---------------------|-----------------------|-------------------------|-----------------------------------|--|
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Multiple Surgery | Workers’ Comp Allowed Amt. | Notes |
| 63650-59 | \$ 6542.56 | \$0 | \$ 4184.40 | N/A | \$ 4184.40 | DISPUTED SERVICE: Allow reimbursement of the full allowable amount. |

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