

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

10/20/2014

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██
██

IBR Case Number:	CB13-0000921	Date of Injury:	04/15/2004
Claim Number:	████████████████████	Application Received:	12/20/2013
Claims Administrator:	██		
Date(s) of service:	██		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	64555, 64555-59 x 3 units, 63691 and 76000-26		

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 04/14/2014, 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 \$686.01, for a total of \$1021.01.**

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

Analysis and Findings:

Based on review of the case file the following is noted:

ISSUE IN DISPUTE: Provider dissatisfied with reimbursement of codes 64555, 64555-59 x 3 units, 63691, and 76000-26.

- Provider billed for CPT codes 64555, 64555-59 x 3 units, 69691, and 76000-26 for “Bilateral lumbar peripheral nerve stimulator trial under fluoro/anesthesia”. The claim was denied as follows: “Based upon clinical review, this service/procedure was denied as not medically necessary, based on the documentation provided on this date.”
- A request for second review resulted in the claim being denied as duplicate.
- CPT code 64555 – Percutaneous implantation of neurostimulator electrodes; peripheral nerve
- CPT code 63691 – Electronic analysis of implanted neurostimulator pulse generator system (may include rate, pulse amplitude and duration, configuration of wave form, battery status, electrode select-ability, output modulation, cycling, impedance and patient compliance measurements); with reprogramming of pulse generator.
- CPT code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)
- Modifier 59: “Distinct procedural service” Modifier 26: “Professional component”
- The provider submitted an authorization from [REDACTED] for the nerve stimulator trial dated 07/09/2013, as well as an authorization from [REDACTED] for the permanent placement of the stimulator dated 09/17/2013.
- Authorization of the permanent placement of the nerve stimulator states “It was discussed that the patient had positive results from the peripheral nerve stimulator implant (trial). He [REDACTED] did provide the psychological evaluation. The patient has initiated weaning of narcotics. There was better function, better sleep, and less medication requirements during the peripheral nerve stimulator trial. The recommendation is to certify.”

DETERMINATION OF DISPUTE: Reimbursement of CPT 64555, 64555-59 (x 3 units), 63691 and 76000-26, should have been based on the Official Medical Fee Schedule allowance. An additional reimbursement of \$686.01 is to be made to the Provider.

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

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amount	Notes
Date of Service – 07/25/2013						
Physician Services/Pathology and Laboratory Services						

64555	\$7500.00	\$0.00	\$153.00	1	\$153.00	DISPUTED SERVICE – Additional reimbursement to be made for \$153.00
64555-59	\$22,500.00	\$0.00	\$459.00	3	\$459.00	DISPUTED SERVICE – Additional reimbursement to be made for \$459.00
63691	\$150.00	\$0.00	\$43.61	1	\$43.61	DISPUTED SERVICE – Additional reimbursement to be made for \$43.61
76000-26	\$60.00	\$0.00	\$30.40	1	\$30.40	DISPUTED SERVICE – Additional reimbursement to be made for \$30.40

Determination: Reversed

Chief Coding Specialist Decision Rationale:

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 of (\$686.01) for a total of \$1021.01.

The Claims Administrator is required to reimburse the provider \$1021.01 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,

Chief Coding Reviewer

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