

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 7, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000574	<b>Date of Injury:</b>	09/26/2011
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	04/14/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	06/19/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	63660-58 and 63660-58-59		

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 \$250.00 for the review cost and \$463.49 in additional reimbursement for a total of \$713.49. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$713.49 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: None
- National Correct Coding Initiatives
- Other: Official Medical Fee Schedule, Physician Services

## 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 reimbursement of CPT codes 63660-58 and 63660-58-59.
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Claims Administrator reimbursed Provider \$1149.90 for date of service 11/11/2013 indicating on the Explanation of Review "This charge was adjusted to comply with the rate and rules of the contract indicated." Overview of contract Prudent Buyer Fee Schedule effective 09/01/2011 received, CPT code 63660 is not located. CPT 63661 appears on the discount sheet in the amount of \$766.60 for Non-Facility Rate. Claims Administrator reimbursed CPT 63660-58 in the amount of \$766.60 and 63660-58-59 in the amount of \$383.30, adjusted per multi-surgery procedure rules. It appears that Claims Administrator based reimbursement on CPT code 63661 from the PPO Contract, not 63660 from the Official Medical Fee Schedule.
- Provider billed codes 63660-58 and 63660-58-59 and documents procedure performed on the Operative Report as removal of dual spinal cord stimulation. Provider billed second 63660 with a modifier 59 – Distinct Procedural Service.

- Based on 1997 CPT Guidelines and information reviewed, Claims Administrator was incorrect to reimburse based on the PPO Contract. Provider was correct to bill code assignment 63660-58 and 63660-58-59 and should be reimbursed based on the Official Medical Fee Schedule as stated in the PPO Contract. Multi-surgery rules will apply as 63660-58 to be reimbursed at 100% and 63660-58-59 to be reimbursed at 50% of OMFS.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of codes 63660-58 and 63660-58-59 is warranted.**

Date of Service: 11/11/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63660-58	\$2500.00	\$ 766.60	\$ 308.99	100%	\$1075.59	<b>DISPUTED SERVICE: Allow reimbursement \$308.99</b>
63660-58-59	\$2500.00	\$ 383.30	\$154.50	50%	\$537.80	<b>DISPUTED SERVICE: Allow reimbursement \$154.50</b>

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