

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 18, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001387	Date of Injury:	03/20/1988
Claim Number:	[Redacted]	Application Received:	08/19/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	04/09/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63650 x 2(not in dispute) and 63685-58		

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 \$195.00 for the review cost and \$13,927.52 in additional reimbursement for a total of \$14,122.52. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$14,122.52 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,

Paul Manchester, MD, MPH  
Medical Director

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: N/A
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

## 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 denial of code 63685. Provider is not disputing code 63650 x 2 units.
- Claims Administrator denied code with indication “The procedure code is disallowed based on CPT rules; Labor code 5307.1”
- Authorization to Schedule Certified Procedure dated 03/10/2015 shows “Please sign, date and fax back this form as your acknowledgement of certification and your final approval to schedule the certified procedure AT the facility below: Procedure - spinal cord stimulator revision & IPG replacement” which is signed by authorized claims adjuster and dated 3/11/2015.
- Provider billed code 63685 along with 63688 which Claims Administrator did reimburse.
- As a pair code exists between codes 63685 and 63688, Modifier Indicator shows ‘1’ which states that if an approved modifier is appended to the column ‘2’ code, and documentation is supports code billed then the edit may be overridden.
- 63685 is the column ‘1’ code and is the primary procedure per Operative Report submitted.
- Provider submitted a “Corrected Claim” notice requesting 63688 be removed and only bill 63685.

- Based on aforementioned, reimbursement of 63685 is warranted. As Claims Administrator

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 63685**

<b>Date of Service: 04/09/2015</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
63685	\$32,000.00	\$0.00	\$13,927.52	100%	\$13,927.52	<b>DISPUTED SERVICE:</b> Allow reimbursement \$13,927.52

**National Correct Coding Initiative information:**

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier Allowed?</b>
Hospital APC Version 21.1	63685	63688	Yes

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