

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 19, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001676	Date of Injury:	10/27/2008
Claim Number:	[REDACTED]	Application Received:	09/21/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/19/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63661 x 3		

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 \$758.86 in additional reimbursement for a total of \$953.86. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$953.86 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
- National Correct Coding Initiatives
- Other: CMS Chapter 8 codes 60000-69999 1/1/2014 NCCI Policy Manual

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 codes 63661 x 3 units
- Claims administrator denied codes indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day””
- Operative Report received documents 1 electrode was removed on date of service 5/19/2015.
- CCR § 9789.30, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the 2014 Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register.
- Per CMS 2014 NCCI Edit Policy Manual: The MUE values for CPT code 63661 (removal of spinal neurostimulator electrode percutaneous array(s)...) and CPT code 63662 (removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy...) are one (1). Each code descriptor includes the removal of some or all electrode percutaneous arrays and some or all electrode plates/paddles for a neurostimulator pulse generator. If a patient has two separate neurostimulator pulse generators and some or all electrodes are removed for each neurostimulator pulse

generator separately, the removal of the percutaneous array(s) or plate(s)/paddle(s) for the **second neurostimulator pulse generator may be reported with modifier 59.**

- Based on aforementioned guidelines, reimbursement of one (1) unit of 63661 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 63661

Date of Service: 05/19/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63661	\$21,093.05	\$0.00	\$3,350.37	1	N/A	\$758.86	DISPUTED SERVICE: Allow reimbursement \$758.86

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]