

**MAXIMUS FEDERAL SERVICES, INC.**

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



---

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 20, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001913	Date of Injury:	07/11/2011
Claim Number:	[Redacted]	Application Received:	10/16/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/23/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63650 x 2, 63685, and 95972		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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: PPO Contract
- National Correct Coding Initiatives

## 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 seeking remuneration of billed codes 63650 x 2, 63685, and 95972 on date of service 03/23/2015
- Claims Administrator's reimbursement rationale indicates "A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated rate."
- A copy of the contract was not received for this review.
- Provider billed codes on a CMS 1500 with place of service '24'.
- Authorization dated February 20, 2015 states "Spinal cord stimulator implant x2 leads"
- The percutaneous implantation of neurostimulator electrodes code 63650 represents implantation of a single lead. Per coding guidelines, procedure code 63650 can be separately reported for placement of any additional electrode catheter(s) or plate(s)/paddle(s) by appending either modifier 51 (same anatomic site) or modifier 59 (different anatomic site) to the appropriate code. An array is a collection of electrical contacts on a single catheter, plate, or paddle. All neurostimulator electrode arrays have leads with multiple contact electrodes. Using present CPT coding convention, in spinal cord stimulation (63650) as an example, reporting is based on the number of electrode catheter, electrode plate, or electrode paddle "arrays" inserted.

- Operative Report documents “the lead was then threaded through the epidural space and placed at T8. A second lead was placed in the same manner.”
- Per coding guidelines, 63650 is to be billed on separate lines with an appended modifier. Provider did not bill appropriately and therefore, additional reimbursement of 63650 is not warranted.
- EOR reflects a PPO discount was applied to reimbursement of 63650 and 63685. Provider is not denying a contract agreement between the two parties.
- § 9792.5.7 (b) unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code 5307.11 shall be resolved before seeking independent bill review.
- As a copy of the PPO contract was not submitted for review, additional reimbursement of 63650 and 63685 is not warranted.
- Claims Administrator denied code 95972 indicating “The procedure or service billed is rarely, if ever, performed for the conditions for which the patient is being treated. Please provide an explanation of the medical necessity of this service.”
- 95972: Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, up to 1 hour.
- Operative Report documents “Multiple reprogramming was done”
- Documentation does not support billed code and therefore, reimbursement is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 63650 x 2, 63685, and 95972.

<b>Date of Service: 03/23/2015</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
63650	\$5600.00	\$589.09	\$719.99	2	100%	\$589.09	Refer to Analysis
63685	\$2300.00	\$246.02	\$44.56	1	50%	\$246.02	Refer to Analysis
95972	\$180.00	\$0.00	\$50.19	1	50%	\$0.00	Refer to Analysis

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]