**MAXIMUS FEDERAL SERVICES, INC.**
Independent Bill Review
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# INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 11, 2016

[redacted]

| | | | |
|---|---|---|---|
| IBR Case Number: | CB16-0000237 | Date of Injury: | 06/19/2010 |
| Claim Number: | [redacted] | Application Received: | 02/16/2016 |
| Claims Administrator: | [redacted] | | |
| Date(s) of service: | 11/09/2015 | | |
| Provider Name: | [redacted] | | |
| Employee Name: | [redacted] | | |
| Disputed Codes: | 63650 x 2 and 64575 x 2 | | |

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, M.D., M.P.H.
Medical Director

[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
- OMFS

## 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 for 63650 Percutaneous implantation of neurostimulator electrode array, epidural x 2 units and 64575 Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) epidural x 2 units performed on 11/09/2015.**
- The Claims Administrator reimbursed the provider for 1 unit each with the following explanation: "charge exceeds the Official Medical Fee Schedule allowance."
- CPT 65350 Wt 63.6628; CPT 64575 Wt 102.1644
- **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. The adjustments to these subsections are specified in section 9789.39 by date of service.
- 63650 is a status indictor of "S" and is subject to multiple procedure reimbursement methodology.
- ASC Allowable Modifiers: 25, 27, 50, 52, 58, **59,** 73, 74, 76, 77, 78, 79, 91, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GG, GH, LC, LD, LM, LT, RC, RI, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA
- Operative report indicates 2 electrodes placed at T8.

- **Article 5.5.0**. Rules For Medical Treatment Billing and Payment §9792.5.7. Requesting Independent Bill Review (b)(2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- **UB-04 indicates 4 services billed as 2 line items with multiple units** reflecting incorrect submission of separately billable procedures. Additionally, Modifier -59 distinct procedure/service, is not appended to the claim to indicate separate procedures were performed.
- **EOR's indicate 1 unit each, 63650 & 64575.** Reimbursement verified; APC relative weight x adjusted conversion factor $83.81 x 0.808 Workers' Compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service (2014 pursuant to CCR § 9789.30).
- **Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for 63650 and 64575.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 63650 x 2 units and 64575 x 2 units**

**Date of Service**: 11/09/2015
Ambulatory Services

| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes |
|---|---|---|---|---|---|---|
| 63650 | $60,000.00 | $4,285.93 | $4,284.94 | 2 | $4,285.93 | **Refer to Analysis** |
| 64575 | $80,000.00 | $6,877.95 | $6,876.33 | 2 | $6,877.95 | **Refer to Analysis** |

[redacted]

[redacted]

[redacted]