

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 16, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000248	Date of Injury:	09/12/2014
Claim Number:	[REDACTED]	Application Received:	02/18/2016
Assignment Date:	March 9, 2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	09/08/2015 – 09/08/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63030 and 63035		

Dear [REDACTED]

MAXIMUS Federal Services has completed an amended Independent Bill Review (“IBR”) of the above workers’ compensation case. A miscalculation occurred during the original final determination letter. This letter provides you with the correct reimbursement for 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

[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: 95% PPO Reimbursement
- 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 seeking remuneration of 63035 Thorax spine disk surgery and 63030 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar for Hospital Outpatient Services performed on 09/08/2015.**
- Provider billed codes on a UB-04 with claim type 131.
- Claims Administrator denied CPT 63035 with the following rational: “No separate payment was made because the value of the service is included in the value of another service performed on the same day.”
- **63035** has a status indicator ‘N’ – **Packaged**, Paid under OPPTS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. Items and Services Packaged into APC Rates.
- **Title 8, CCR §9789.30:** For services rendered on or after September 1, 2014: the item has a **status code N**, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).
- Reimbursement of 63035 is not warranted.

- Effective December 1, 2014, For services rendered on or after December 1, 2014, section 9789.31, subsections (a) and (b) are amended to incorporate by reference selected sections of the updated calendar year 2014 version of CMS' hospital outpatient prospective payment system (HOPPS) published in the Federal Register on December 10, 2013, the updated fiscal year **2014** versions of CMS' IPPS Tables 2, 4A, 4B, 4C, and 4J in the final rule of August 19, 2013 and associated rules and notices to the IPPS final rule, respectively
- Claims Administrator reimbursed \$6,436.00 for CPT 63030 with rationale "the charge exceeds the fee schedule allowance."
- Correct allowable amount calculated for APC 0208 as follows:  
 $55.0874 * 101.47 * 1.212 = \$6774.70$  Less PPO = \$6,435.97
- PPO contract reflects 95% OMFS.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for 63035 and 63030.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** 63035 and 63030

Date of Service: 08/10/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multi Surg	Workers' Comp Allowed Amt.	Notes
63030	\$17,725.00	\$6,436.00	\$383.75	100%	\$6,436.00	\$0.00 Due to Provider Refer to Analysis
63035	\$17,725.00	\$0.00	\$17,725.00	100%	\$0.00	\$0.00 Due to Provider Refer to Analysis

[REDACTED]

[REDACTED]