

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 24, 2016

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

IBR Case Number:	CB16-0000797	Date of Injury:	04/08/1999
Claim Number:	[REDACTED]	Application Received:	05/13/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/28/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64635-SG and 64635-50-SG		

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 \$1,385.18 in additional reimbursement for a total of \$1,580.18. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1,580.18 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,

Maximus

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
- 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 the following Ambulatory Services performed on 12/28/2015: 64635-SG and 64635-SG-50**
- Claims Administrator reimbursement rationale: “The charge for this procedure exceeds the fee schedule allowance.”
- SG Modifier = Ambulatory Surgical Center
- **UB-04 Bill Type 831**
- Provider’s facility holds a valid and current license from the AAAHC in accordance with to §9789.30 (c) Hospital Outpatient Departments and Ambulatory Surgical Centers.
- **CPT 64635 = Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint. Bilateral Indicator of “1.” 2014 ASC Payment Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.**
- Operative note indicates “Radiofrequency Lumbar Medial Branch Neurotomy at: L3, L4 and L5 bilaterally with cinefluoroscopy and fluoroscopically guided needle placement.”
- CPT 64635 = Bilateral indicator of “1” with the following 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.
- UB-04 Indicates 64635 x 1 Unit and 64635 -50.
- §9789.16.6. Surgery - Bilateral Surgeries (B) If Bilateral Surgery column of the National Physician Fee Schedule Relative Value File contains an indicator of

“1,” the standard payment adjustment for bilateral procedures apply. Payment is determined by the lower of the billed amount or 150 percent of the fee schedule amount. (Multiply the payment amount for the surgery by 150 percent.).

- Opportunity for Claims Administrator to Dispute sent on 6/6/2016. A response was not received for this review.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 64635 & 64635-50.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 64635-SG and 64635-SG-50**

<b>Date of Service:</b> 12/28/2015						
<b>Ambulatory Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
64635	\$3200.00	\$515.94	\$1095.43	1	\$1611.37	\$1095.43 Due to Provider
64635-50	\$1300.00	\$515.94	\$289.75	1	\$805.69	\$289.75 Due to Provider

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