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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 28, 2016

[redacted]

IBR Case Number:	CB16-0000871	Date of Injury:	06/18/2015
Claim Number:	[redacted]	Application Received:	05/25/2016
Assignment Date:	06/21/2016		
Claims Administrator:	[redacted]		
Date(s) of service:	02/01/2016 – 02/01/2016		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	63056-59 and 63057		

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,

MAXIMUS

Cc: [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 63056-59 and 63057 submitted for date of service 02/01/2016.**
- EOR's indicate service denied per NCCI Edits.
- AMA CPT Code Description:
    - 63056 Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc),
    - 63057 add-on Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (list separately in addition to code for primary procedure)
    - Modifier – 59 "Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual…"
- Provider references CPT code description for main procedure performed which excludes decompression. Additionally, the disputed codes should be allowed in consideration for "additional benefits for the additional work."
- NCCI Edits reveal the following code pairs for services performed during the same session and same patient encounter on 02/01/2016:

Column 1	Column 2	CCI Edit Description*	Modifier Indicator	Effective Date*
short description for column 1 code				
	short description for column 2 code			
LUMBAR SPINE FUSION COMBINED				
22633	63056	Standards of medical / surgical practice	1	1/1/2012
	DECOMPRESS SPINAL CORD LMBR			

- **§ 9789.12.13 Correct Coding Initiative (a) The** National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment for services performed on the same day.
- **Pursuant to Labor Code section 5307.1(g)(2),** 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. The adjustments to these subsections are specified in section 9789.39 by date of service. Subsection (c) and (d) are adjusted to incorporate by reference the **2014 Fiscal Year** IPPS Payment Impact File and the Medicare Physician Fee Schedule Relative Value File, respectively. The adjustments to these subsections are specified in section 9789.39 by date of service. Subsection (e) is adjusted to incorporate by reference the **2014** revision of the American Medical Associations' Physician "Current Procedural Terminology"; and subsection (f) is adjusted to incorporate by reference the **2014** revision of CMS' Alphanumeric "Healthcare Common Procedure Coding System".

- **National Correct Coding Initiative Policy Manual for Medicare Services, Revision Date January 1, 2014, E(1)(d): Modifier 59 is used to identify procedures/services** other than E/M services, that are not normally reported together, but are appropriate under the circumstances. **Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual**. (Emphasis added)
- Although a 59 modifier is appended to the disputed (parent) code, the Operative Report does not indicate the services were not performed at a separate anatomical site or session from the Arthrodesis.
- The Provider requests "additional benefits for the additional work," be taken into consideration for this claims. IBR unable to determine medical necessity.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for 63056-59 and 63057.**

The table on page 5 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 63056-59 and 63057

Date of Service: 02/01/2016 Physician Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
63056-59 and 63057	$9,200.00	$0.00	$2,620.18	1 & 1	$0.00	**Refer to Analysis**

Copy to:

[redacted]

[redacted]