

**MAXIMUS FEDERAL SERVICES, INC.**

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

---

**Independent Bill Review Final Determination Reversed**

1/29/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 2/11/2013 – 2/11/2013  
MAXIMUS IBR Case: CB13-0000418

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/20/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$630.17, for a total of \$965.17.**

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- 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 or negotiated contract: PPO Contract
- Other: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013)

**Supporting Analysis:**

The dispute regards the payment for surgical facility services on date of service 2/11/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64483 Modifier 50. The Provider was reimbursed \$344.21 and is requesting additional reimbursement. The Claims Administrator reimbursed \$315.10 for the billed CPT 64483 Modifier 50, \$1.21 for the billed HCPCS J0704, and \$27.90 for the billed CPT 72100. The Claims Administrator denied billed CPT code 76000 with the explanation, "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated." The Claims Administrator denied billed CPT 94760 with the explanation, "Items and/or services are packaged into APC rate: Therefore, there is no separate APC payment."

CPT 72100 - Radiologic examination, spine, lumbosacral; 2 or 3 views.

CPT 76000 - Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (e.g., cardiac fluoroscopy).

CPT 64483 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level.

CPT 94760 - Noninvasive ear or pulse oximetry for oxygen saturation; single determination  
Modifier 50 - Bilateral procedure.

The Provider is disputing the billed CPT codes 72100, 76000, 64483 and 94760.

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

The provider is a Hospital and is located in Los Angeles County. Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators."

Per Title 8 California Code of Regulations, Section 9789.32, a facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if: (1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2008: the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2009: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit or surgical procedure

(in which case no additional fee is allowable). The billed procedure code 94760 has a status indicator of "N". The billed procedure code 76000 has a status indicator of Q1, and is packaged into the APC payment for surgical procedure code 64483. The denial of the billed procedure codes 94760 and 76000 by the Claims Administrator was correct.

The billed CPT 72100 has a status indicator of "X". The maximum allowable fees for non-surgical ancillary services with a status code indicator "X" shall be determined according to Title 8, California Code of Regulations, Section 9789.10 and Section 9789.11. The Claims Administrator's reimbursement of the billed procedure code 72100 was correct.

The surgical CPT code 64483 has an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The Operative Report documented a lumbar transforaminal epidural steroid injection at bilateral L5-S1. The Provider billed CPT 64483 Modifier 50. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), the payment for these codes is 150% of the fee schedule amount for a single code. The reimbursement by the Claims Administrator was not correct based on the OMFS Outpatient Hospital Fee Schedule and the PPO contract.

The additional reimbursement of \$630.17 is warranted per the Official Medical Fee Schedule code 64483. There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 72100, 76000 and 94760.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
64483	50	1	\$732.49	\$945.27	\$315.10	\$630.17	PPO Contract
72100		1	\$1.47	\$27.90	\$27.90	\$0.00	PPO Contract
76000		1	\$42.72	\$0.00	\$0.00	\$0.00	PPO Contract
94760		1	\$68.65	\$0.00	\$0.00	\$0.00	PPO Contract

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 64483 Modifier 50 (\$630.17) for a total of \$965.17.

***The Claims Administrator is required to reimburse the provider \$965.17 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).***

Sincerely,

[REDACTED], RHIT

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

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