

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 23, 2014

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

IBR Case Number:	CB13-0000568	Date of Injury:	7/20/2005
Claim Number:	[REDACTED]	Application Received:	10/8/2013
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	72100, 76000, 64493, 64494 and 94760		

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. IBR case assigned: 3/28/2014.

**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 \$335.00 for the review cost and \$855.39 in additional reimbursement for a total of \$1190.39. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1190.39 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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

[REDACTED]  
Chief Coding Reviewer

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
- Official Medical Fee Schedule
- Negotiated contracted rates: OMFS
- 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:** The dispute regards the payment for surgical facility services on date of service 3/18/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64493 Modifier 50 and CPT 64494 50
- The Provider is disputing the payment amount of CPT 64494 50; 64493 50; 72100; and the non-payment of CPT codes 76000; and 94760. The Claims Administrator reimbursed \$483.66 for the following CPT codes: 72100 (29.78); 64493 50 (336.34); and 64494 50 (\$117.54) with the following explanation: “The charge was adjusted to comply with the rate and rules of the contract indicated. The charge exceeds the Official Medical Fee Schedule allowance. This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. Recommendation of payment has been allowed based on this procedure code, 64493, which best describes services rendered. Recommendation of payment has been allowed based on this procedure code, 64494, which best describes services rendered.”
- CPT code 76000 was denied reimbursement with the explanation: “The charge exceeds the Official Medical Fee Schedule allowance. This procedure is incidental to the primary procedure, and does not warrant separate reimbursement. Recommendation of payment has been based on this procedure code, 76000, which best describes services rendered.”
- CPT code 94760 was denied reimbursement with the explanation: “Recommendation of payment has been based on this procedure code, 94760, which best describes services rendered. Procedure code not separately payable under Medicare and/or Fee Schedule guidelines. The charge exceeds the Official Medical Fee Schedule allowance.”
- 2013 Current Procedural Terminology (CPT) code definitions:
  - CPT 64493: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
  - CPT 64494: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
  - CPT 76000: Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)
  - CPT 72100: Radiologic examination, spine, lumbosacral; 2 or 3 views
  - CPT 94760: Noninvasive ear or pulse oximetry for oxygen saturation; single determination
  - Modifier 50: Bilateral Procedure
- 150% Bilateral payment adjustment 150% payment adjustment for bilateral procedures applies. 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), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

- The Operative Report documented the following operations as performed on 3/18/2013:
  - Fluoroscopically-guided cannulation of the left L4-5 facet for an infusion of local anesthetic and steroid; Fluoroscopically-guided cannulation of the left L5-S1 facet for an infusion of local anesthetic and steroid; Fluoroscopically-guided cannulation of the right L4-5 facet for an infusion of local anesthetic and steroid; Fluoroscopically-guided cannulation of the right L5-S1 facet for an infusion of local anesthetic and steroid; Interpretation of lumbar facet arthrography at L4-5 on the left; Interpretation of lumbar facet arthrography at L5-S1 on the left; Interpretation of lumbar facet arthrography at L4-5 on the right; Interpretation of lumbar facet arthrography at L5-S1 on the right; and Fluoroscopic needle guidance of the spine
- It was noted a separate report for the interpretation of lumbar facet arthrography was not submitted as part of the documentation.
- CPT 76000 – The Provider is disputing the denial of the CPT code 76000. CPT code 76000 has an assigned status indicator of “Q1.” The services described and reported with CPT 76000 are included in the surgical services provided and reported as 64493 50 and 64494 50; therefore, are not separately reimbursable.
- The Provider is disputing the denial of the CPT code 94760. CPT code 94760 has an assigned status indicator of “N.” Payment Status Indicator definition is “Payment is packaged into payment for other services. No separate APC payment.” The services reported under CPT 94760 are not separately reimbursable and are packaged into the APC payment for the emergency room visit or surgical procedure.
- The services reported as 64493 and 64494 were performed and qualify for separate reimbursement. The allowance was determined based on the following OMFS Outpatient Hospital Fee Schedule formula:
  - CPT 64493 50:  $7.9333 \text{ (APC RW)} \times 77.65 \text{ (Adjusted Conversion Factor)} \times 1.22 = \$751.55 \times 150\% \text{ (bilateral adjustment)} = \$1,127.33$
  - CPT 64494 50:  $2.5607 \text{ (APC RW)} \times 77.65 \text{ (Adjusted Conversion Factor)} \times 1.22 = 242.58 \times 150\% \text{ (bilateral adjustment)} = \$363.87 \times 50\% \text{ (multiple procedure adjustment)} = \$181.94$
- In reviewing the explanation of review, the PPO allowances and reimbursement did not appear to be based on the OMFS Outpatient Hospital Fee Schedule. The reimbursement of CPT 64493 50 indicated a payment of \$336.34 and a discount of \$17.70; the OMFS allowance for this bilateral procedure (64493 50) is \$1,127.33. The reimbursement of CPT 64494 50 indicated a payment of \$117.54 and a discount of \$6.19; the OMFS allowance for this bilateral procedure (64494 50) is \$181.94.
- MAXIMUS requested a copy of the PPO contractual agreement. The PPO contract was not submitted or received by MAXIMUS from either party (Claims Administrator or Provider); therefore, the allowances for 64493 50 and 64494 50 were based on the OMFS Outpatient Hospital Fee Schedule.
- The last code in dispute is CPT 72100. Per the documentation from the Provider, the expected reimbursement for this code was the OMFS allowance minus a PPO discount of 5%. The Provider determined the OMFS allowance was \$33.00. In reviewing the reimbursement from the Claims Administrator, it appears the reimbursement is correct. The OMFS allowance for this CPT code 72100 is based on Section 9789.10 and Section 9789.11, due to the assigned Status Code Indicator “X.” The OMFS allowance for 72100 billed by the

Facility is \$31.35. The Claims Administrator reimbursed \$29.78 and applied a \$1.57 discount (5%). No additional reimbursement is recommended for the billed CPT code 72100.

- In reviewing the operations performed, billed procedure codes and OMFS Outpatient Hospital Fee Schedule it was determined additional reimbursement of \$855.39 is owed on the Outpatient Hospital services performed on 3/18/2013.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 64493 50 and 64494 50.

<b>Date of Service:</b> 3/18/2013						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
72100	\$ 559.00	\$ 29.78	\$ 1.57	N/A	\$ 29.78	<b>DISPUTED SERVICE:</b> No additional reimbursement.
76000	\$ 762.00	\$ 27.78	\$ 45.60	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No additional reimbursement
64493 50	\$ 4993.55	\$ 336.34	\$ 781.88	150% Bilateral Adj.	\$1127.33	<b>DISPUTED SERVICE:</b> Additional reimbursement of 790.99 recommended
64494 50	\$4993.55	\$117.54	\$240.62	150% Bilateral Adj & Mult Procedure Reduction 50%	\$181.94	<b>DISPUTED SERVICE:</b> Additional reimbursement of 64.40 recommended
94760	\$1052.00	\$0.00	\$73.28	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No additional reimbursement recommended

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Hospital APC Version 19.0	64493	76000	Allowed
Hospital APC Version 19.0	64494	76000	Allowed

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
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