

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 29, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|-------------------------------|------------------------------|------------|
| IBR Case Number: | CB13-0000603 | Date of Injury: | 12/15/2010 |
| Claim Number: | [Redacted] | Application Received: | 10/15/2013 |
| Claims Administrator: | [Redacted] | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 76003-26-59,76499-26-59,62289 | | |

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 Claims Administrator owes the Provider additional reimbursement of \$335.00 for the review cost and \$0.00 in additional reimbursement for a total of \$335.00. A detailed explanation of the decision is provided later in this letter.

The Claims Administrator is required to reimburse the Provider a total of \$335.00 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,

[Redacted]
[Redacted]

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: PPO
- National Correct Coding Initiatives
- Other: OMFS Surgery Guidelines

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 dissatisfied with reimbursement of codes 62289, 76499-26/59, 76003-26/59

- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Provider billed CPT codes 62289, 76499-26-59, and 76003-26-59. Explanation of Review (EOR) from the Claims Administrator denied the claim for the following reasons: "This charge is denied as the service was not authorized during the utilization review process." A second review resulted in the same denial.
- CPT Code 62289: Lumbar or Caudal Epidural (separate procedure)
 - Upon Review of the documentation provided, a document entitled "Overriding UR Denial," dated 5/9/13 by the "Sr. Claims Examiner," is present.
 - Operative Report States, "... epidural catheter was advanced through..."
 - The Authorization states, "I authorize the following medical treatment and faxed this note to provider as written notice."

- Specific treatments authorized: “Lumbar Caudal ESI with fluoroscopic guidance and Anesthesia and Norco 10/325 1 Q 4-6 hrs #150.”
- Based on the documented Authorization for the treatment provided, reimbursement is warranted for CPT 62289.
- CPT Code 76499 -26 - 59: Unlisted Diagnostic Radiologic Procedure.
 - Modifier 26: “Professional component”, Modifier 59: “Distinct procedural service”
 - Operative Report states, “Multiple fluoroscopic pictures were reviewed.”
 - Upon Review of the documentation provided, a document entitled “Overriding UR Denial,” dated 5/9/13 by the “Sr. Claims Examiner,” is present.
 - The Authorization states, “I authorize the following medical treatment and faxed this note to provider as written notice.”
 - Specific treatments authorized: “Lumbar Caudal ESI with fluoroscopic guidance and Anesthesia and Norco 10/325 1 Q 4-6 hrs #150.”
 - Based on the documented Authorization for the treatment provided, reimbursement is warranted for CPT 76499 -26 - 59
- CPT Code 76003 -26 – 59: Fluoroscopic localization for needle biopsy or fine needle aspiration
 - Modifier 26: “Professional component”, Modifier 59: “Distinct procedural service”
 - CPT Code 76003 was deleted in 2007, however is relevant to this claim as per the aforementioned labor code.
 - Operative Report states, “Employing 18 gauge Tuohy needle, the sacral epidural space... After negative aspiration...”
 - Upon Review of the documentation provided, a document entitled “Overriding UR Denial,” dated 5/9/13 by the “Sr. Claims Examiner,” is present.
 - The Authorization states, “I authorize the following medical treatment and faxed this note to provider as written notice.”
 - Specific treatments authorized: “Lumbar Caudal ESI with fluoroscopic guidance and Anesthesia and Norco 10/325 1 Q 4-6 hrs #150.”
 - Based on the documented Authorization for the treatment provided, reimbursement is warranted for CPT 76003 -26 – 59

The Claims Administrator subsequently reimbursed the Provider for services after the IBR process. Because the Claims Administrator reimbursed the Provider for services verified by IBR, the amount due to the Provider is the IBR service fee.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 62289, 76499-26-59, and 76003-26-59 to be made based on OMFS and PPO discount. Claims Administrator paid provider in full on 12/12/2013.

The table below describes the pertinent claim line information:

| Date of Service: 5/21/2013 | | | | | | | |
|-----------------------------------|------------------------|---------------------|-----------------------|--------------|-------------------------|-----------------------------------|---|
| [REDACTED] | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 62289 | \$ 675.00 | \$ 208.08 | \$ 675.00 | 1 | N/A | \$ 208.08 | DISPUTED SERVICE: No Additional Reimbursement Due. |
| 76499-26-59 | \$ 150.00 | \$ 127.50 | \$ 150.00 | 1 | N/A | \$ 127.50 | DISPUTED SERVICE: No Additional Reimbursement Due. |
| 76003-26-59 | \$ 180.00 | \$ 32.30 | \$ 180.00 | 1 | N/A | \$ 32.30 | DISPUTED SERVICE: No Additional Reimbursement Due. |

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]
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Copy to:

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