

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280

**Independent Bill Review Final Determination Reversed**

9/19/2014

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████████████████  
████████████████████

|                       |  |                       |            |
|-----------------------|--|-----------------------|------------|
| IBR Case Number:      | CB13-0000858                             | Date of Injury:       | 07/08/2002 |
| Claim Number:         | ████████████████                         | Application Received: | 12/13/2013 |
| Claims Administrator: | ██ |                       |            |
| Date(s) of service:   | 5/14/2013 – 5/14/2013                    |                       |            |
| Provider Name:        | ██ |                       |            |
| Employee Name:        | ██ |                       |            |
| Disputed Codes:       | 00630 AA QS                              |                       |            |

Dear ██████████:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/28/2014, 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 \$95.03, for a total of \$430.03.**

**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 Anesthesia Ground Rules and Fee Schedule , AMA CPT

## Supporting Analysis:

The dispute regards the payment amount for anesthesia services. The Provider billed Anesthesia CPT Code 00630 Modifier AA QS, was reimbursed \$155.69 and is requesting additional reimbursement of \$139.33.

The Claims Administrator reimbursed \$155.69 with the following reasons/explanations:

- Recommended allowance based on negotiated discount/rate
- The procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing
- The allowance is based on the anesthesia service personally performed by anesthesiologist

For discussion purposes, the codes in question will be defined. The American Medical Association 1997 Current Procedural Terminology defines CPT Code 00630 is as follows:

- **CPT 00630:** Anesthesia for procedures in lumbar region; not otherwise specified.

The Modifiers are not listed in the 1997 OMFS; definitions provided only for informational purposes.

- **CPT Modifier AA:** Anesthesia services performed personally by anesthesiologist
- **CPT Modifier QS:** Monitored anesthesia care service

The documentation submitted included an Operative Report, Medical Necessity for Anesthesia, Anesthesia Report and Anesthesia Record; important elements to define CPT 00630 will be abstracted from each and presented below.

Anesthesia Record indicated the following:

1. Start time of "10:46"
2. End time of "11:00"
3. Monitoring of the patient, by the Anesthesiologist, during the administration of the anesthesia.
4. "Patient failed monitored anesthesia care."
5. "Patient could not stay still for procedure, requiring more extensive anesthesia."

Operative Report indicated the following operations/procedures were performed:

- Transforaminal Epidural L4-5 Right
- Transforaminal Epidural L4-5 Left

Assigned ICD-9 (Diagnosis) Codes to support the need for CPT 00630: 427.9 Cardiac dysrhythmia, unspecified; 429.2 Cardiovascular disease, unspecified; 435.9 Unspecified transient cerebral ischemia and 308.3 Other acute reactions to stress

Findings of this review conclude the requirements of CPT 00630 were met based on the documentation submitted by the provider.

The allowance was calculated based on the PPO Contract. The additional reimbursement of \$95.03 is warranted per the Official Medical Fee Schedule code 00630 AA QS.

The chart below provides a comparison of disputed 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 |
|----------------|--------------------|-----------------|----------------|------------------------------|----------------------|-----------------------------------|-----------------------|
| 00630          | AA, QS             | 9               | \$139.33       | \$250.72                     | \$155.69             | \$95.03                           | PPO                   |

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 00630 Modifier AA, QS (\$95.03) for a total of \$430.03.

***The Claims Administrator is required to reimburse the provider \$430.03 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,

██████████, RHIT  
Chief Coding Reviewer

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