

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 9, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001846	Date of Injury:	01/30/2013
Claim Number:	[Redacted]	Application Received:	12/01/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/5/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64483-RT, 64483-LT		

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,

Paul Manchester, MD, MPH
Medical Director

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:
- 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:** Provider is dissatisfied with denial of codes 64483-RT and 64483-LT.
- Claims administrator denied codes indicating on the Explanation of Review “Payment denied/reduced for absence of, or exceeded, pre-certification/authorization pre-authorization was not obtained and treatment was rendered without the approval of treating doctor. If you require additional information regarding this bill decision, contact the claim handler.”
- The Provider submitted a copy of the RE: Request for Authorization of Medical Treatment form dated June 17, 2014. The Utilization Review indicated the requested procedure is approved: Transforaminal ESI Bilateral L4-L5 and Chiro/Pt 2 x 4 as ordered by [REDACTED].” This authorization applies only to the specific services listed above and expires within 90 days.” The Utilization Review was addressed to another physician/surgeon not documented on the UB-04 claim form and Operative Report. The Operative report documented procedures performed on 7/30/2014: Transforaminal epidural at the bilateral L4-5 nerves; epidurography; Fluoroscopy for spinal injections and Review of Record. The physician who signed the report was not the provider on the authorization form.

- An exhaustive search for provider on the UB-04 and Operative report was performed by the Maximus reviewer which did not find the physician as a part of the surgery centers network of providers.
- No documentation was submitted to verify if the performing physician is a part of the network and therefore, no reimbursement is warranted for codes 64483-RT and 64483-LT.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service:						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64483-RT	\$6000.00	\$0.00	\$549.33	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
64483-LT	\$6000.00	\$0.00	\$274.67	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]