

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 26, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001250	Date of Injury:	04/08/2009
Claim Number:	[Redacted]	Application Received:	07/31/2015
Assignment Date:	08/19/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	05/18/2015 – 05/18/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64520-RT		

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 Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$543.09 in additional reimbursement for a total of \$738.09. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$738.09** 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,

Paul Manchester, M.D., M.P.H.
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
- OMFS

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 seeking remuneration for 64520 injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic services performed on 05/18/2015.**
- The Claims Administrator's reimbursement rational based on "included" service.
- EOR and UB-04 reflects two procedures, 64520 – RT & 95970, performed with multiple related line item services.
- NCCI Code Pair reflects Colum 1, 64520 & Colum 2, 95970
- Medicare Billing Manual, Page I6, paragraph 1: Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment.
- For services rendered on or after December 1, 2014, § 9789.30, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the 2014 Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register. The adjustments to these subsections are specified in section 9789.39 by date of service.
- For services rendered on or after September 1, 2014, APC relative weight x adjusted conversion factor x 0.808 workers' compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 64520 – RT.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 64520

Date of Service: 05/18/2015 Ambulatory Surgery						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
64520	\$3,000.00	\$501.84	\$238.16	1	\$588.60	-45.51 for 95970 = \$543.09 Due Provider
95970	\$3,000.00	\$45.51	N/A	1	N/A	Refer to Analysis

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