

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 27, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000610	Date of Injury:	08/13/2004
Claim Number:	[REDACTED]	Application Received:	04/21/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/17/2014 – 11/17/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64640-SG, 64633-SG, and 64634-SG		

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 \$852.10 in additional reimbursement for a total of \$1047.10. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$1047.10** 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
- Official Medical Fee Schedule

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 64640-SG, 64633-SG, and 64634-SG.**
- Claims Administrator denied reimbursement stating “Based upon Clinical Review, this service/procedure was denied as not medically necessary, based on the documentation provided on this date.”
- Letter dated 11/12/2014 from Utilization Review indicates: Treatment Plan Requested: Radiofrequency Cervical Medical Branch Nerve Block at C2, C3, TON left side. Determination: Certified; Authorization Timeframe: 11/03/2014 – 01/03/2015
- Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS’ hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, and Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The surgical code 64633 has assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. Code 64640 has P3 - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs.
- 64634 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure) However, the surgical CPT code 64634 has an assigned indicator of "N". The N indicator definition is "Paid under OPPS; Payment is packaged into payment for other services. Therefore, there is no separate APC payment."
- Authorization for Date of Service 10/15/2014, signed by the Claims Administrator on 11/28/2014, indicates disputed HCPCs codes and the expected payment.
- Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 64640-SG and 64633-SG.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 64640-SG and 64633-SG.

Date of Service: 11/17/2014						
Ambulatory Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
64640-SG	\$750.00	\$0.00	\$750.00	2	\$284.03	Allow reimbursement \$284.03
64633-SG	\$1500.00	\$0.00	\$1500.00	1	\$568.07	Allow reimbursement \$568.07

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