

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 6, 2015

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

IBR Case Number:	CB15-0000650	Date of Injury:	02/28/2006
Claim Number:	██████████	Application Received:	04/24/2015
Claims Administrator:	██████		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	99144 and 62311		

Dear ██████████ :

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: ████████
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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
- National Correct Coding Initiatives
- Other: OMFS Physician's 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:** The denial of CPT 62311 and 99144 for date of service 01/13/2015.
- The provider initially billed 00630-59, and later rebilled as 99144-59. Anesthesia Record documented a start time of 1300 and end time 1309, time of 9 minutes. Per CPT coding guidelines and code definition, CPT 99144 is a time based code.
 - A unit of time is attained when the midpoint has been passed. Therefore, in order to report code 99144, whose time unit is 30 minutes, 16 minutes or more (to attain midpoint) of the service as described by the code, must be provided. If the time threshold has not been met, the conscious sedation service is not reported.
- Reimbursement is not recommended for CPT 99144.
- Initial billing was for CPT 62311, 00630 and 72275.
- NCCI edits review based on initial billing: NCCI edits indicate CPT 00630 is not reported with CPT 72275. The anesthesia services included in procedure (72275). Provider was reimbursed \$197.20 for CPT 72275. Services described by CPT 62311 are bundled in and not separately reimbursable when reported with CPT 00630. CPT 62311 was not billed with a modifier.
- The corrected claim indicated the rebilling of CPT 00630 as 99144. Upon review of the NCCI edits based on the corrected claim, CPT 62311 is a column 1 code and CPT 72275 is a column 2 code. CPT 72275 was not billed with a modifier; therefore, both CPT

codes would not be separately reimbursable. Due to the initial billing error, the Claims Administrator reimbursed CPT 72275 as the primary procedure and denied 62311 as bundled. CPT 72275 has a higher allowance of 197.20 than CPT 62311 \$119.49. Additional reimbursement is not recommended for CPT 62311.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 62311 and 99144.

Date of Service 1/13/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
62311	\$ 1122.00	\$ 0.00	\$ 1122.00	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
99144	\$187.15	\$0.00	\$187.15	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
72275	\$200.00	\$197.20	N/A	N/A	N/A	N/A	NOT A DISPUTED CODE

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