

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 10/4/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64483 LT and 64484 LT. The Claims Administrator denied the surgical facility services with the following explanation "Pre-authorization not obtained."

- **CPT 64483:** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
- **CPT 64484:** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

Per the Independent Bill Review application, the Provider is disputing the denial of 64483 LT and 64484 LT with the reason "The claim for this procedure was pre-approved and authorized. Authorization was good through 10/6/2013."

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 CPT codes 64483 and 64484 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The APC weights are determined by the APC code assigned by the Outpatient Prospective Payment System Calculator.

The Provider submitted a copy of the "Utilization Review and Determination & Authorization" form dated August 22, 2013. The Utilization Review indicated the requested procedure: Transforaminal ESI and location: left L4 and L5 lumbar Spine was certified from 8/22/2013 thru 10/6/2013. The Utilization Review was address to the attending physician/surgeon documented on the UB-04 claim form and Operative Report. The Operative report documented the following procedures performed on 10/4/2013: Transforaminal epidural Left L4; Transforaminal epidural Left L5; epidurography; and Fluoroscopy for spinal injections.

Based on a review of Utilization Review document and medical record, the transforaminal ESI procedures performed on the lumbar spine on date of service 10/4/2013 were authorized and performed within the authorized date range; therefore, reimbursement is warranted for the billed surgical facility fees for procedure codes 64483 and 64484.

The reimbursement of \$661.00 is warranted per the Official Medical Fee Schedule surgical facility service codes 64483 and 64484.

The chart below provides a comparison of billed 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
64483	LT	1	\$6000.00	\$525.50	\$0.00	\$525.50	OMFS
64484	LT	1	\$3000.00	\$135.50	\$0.00	\$135.50	OMFS

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 codes 64483 and 64484 Modifier LT (\$661.00) for a total of \$996.00.

The Claims Administrator is required to reimburse the provider \$996.00 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,

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