

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001389	Date of Injury:	1/5/1993
Claim Number:	[REDACTED]	Application Received:	9/22/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/13/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	62311		

Dear Spanish Hills Surgery Center:

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 \$250.00 for the review cost and \$538.05 in additional reimbursement for a total of \$788.05. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$788.05 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,

Dawn M. N. Ossont, RHIT, CCS
Chief Coding Reviewer

cc: [REDACTED]
Division of Workers’ Compensation (DWC) Medical Unit

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: none
- 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:** Denial of CPT code 62311.
- Based on the NCCI edits CPT code 62311 can be reimbursed.
- Based on review of the operative report the injection, of therapeutic substance, including needle or catheter placement, lumbar or sacral, was performed, therefore 62311 should be reimbursed.
- The case file indicates that the service was denied as not authorized by the plan.
- A letter dated March 15, 2014 indicates that an appeal review was performed and the request of the epidural injection between 1/23/14-5/11/14 was certified, therefore code 62311 should be reimbursed.
- Reimbursement is calculated as follows:
Adjusted CF \$82.71 x APC RW 7.9333 x WC Mult. .82 = \$538.05

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of \$538.05 is due to the Provider for CPT code 62311.

Date of Service: 3/27/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Mult Surg	Workers' Comp Allowed Amt.	Notes
62311	\$ 3000.00	\$ 0	\$ 549.33	100%	\$ 538.05	DISPUTED SERVICE: Reimbursement of \$538.05 to be made.

Copy to:






Copy to:

Division of Workers' Compensation Medical Unit
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