

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 17, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0000452	<b>Date of Injury:</b>	06/14/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	03/24/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	09/23/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	62310, 62275, 90780, 99144, 76000-26, 77003-26		

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 \$335.00 for the review cost and \$0.00 in additional reimbursement for a total of \$335.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$335.00 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]

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

## 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 \$381.96 remuneration 62275/62310, 90870/99144, & 76000-26/77003 -26 services performed on 01/10/2014
- EOR 02/04/2014, 62275, Inject spinal anesthetic & 90870 Electroconvulsive therapy, Claims Administrator denied reimbursement stating, “Code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the Provider’s jurisdiction.”
- EOR 02/22/2014 CPT Codes 62275, 90870, resubmitted by Provider as 62310 Inject spine cerv/thoracic & 99144, Moderate Sedation.
- Claims Administrator denied services 62310 and 99144 as “duplicate” charge or service.
- EOR 02/04/2014 CPT 76000-26 Fluoroscope Examination, reimbursed \$13.44 by Claims Administrator.
- EOR 02/22/2014 CPT 76000-26, resubmitted by Provider as 77003-26 Fluoroguide for spine injection.
- Claims Administrator denied 77003-26 as “duplicate” charge or service.
- Request for Authorization for “cervical epidural steroid block” approved on 12/30/2013.
- Authorization is for one ‘cervical epidural steroid block.’ No expiration date expressed or inferred.
- Services authorized and performed as reflected on the Patient “Encounter” Form, 1/10/2014.
- Provider received remainder of payment on 08/1/2014 by the claims administrator.
- Total Payment received for Authorized Services = \$381.96

- Total Payment expected from Provider for Services = \$381.96
- IBR Filing Fee Due To Provider for Authorized Services rendered.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes 62275/62310, 90870/99144, & 76000-26/77003 -26

Date of Service: 01/10/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
62275 as 62310	\$267.10	\$ 0.00	\$127.32	N/A	N/A	\$127.32	<b>Full Payment Made To Provider, IBR Processing Fee Due to Provider</b>
90870 as 99144	\$114.86	\$13.44	\$127.32	N/A	N/A	\$127.32	<b>Full Payment Made To Provider, IBR Processing Fee Due to Provider</b>
76000-26 as 77003-26	\$75.00	\$0.00	\$127.32	N/A	N/A	\$127.32	<b>Full Payment Made To Provider, IBR Processing Fee Due to Provider</b>

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