

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 18, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000479	<b>Date of Injury:</b>	02/11/1997
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	03/24/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	08/01/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	64483, 64484-RT and 64484-RT-59		

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: 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,

[Redacted]  
[Redacted]

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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: ██████████ Authorization

## 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 64483, 64484-RT and 64484-RT-59
- Claims Administrator denied codes and indicated on the Explanation of Review “The services provided were not authorized by Claims Administrator and/or were denied by our UR department.”
- Documentation reviewed included the Authorization approving submitted charges sent to Provider dated November 1, 2013. Authorization is very specific stating: 1. the prospective request for 1 transforaminal epidural steroid injection right side L4, L5, S1 between 09/11/2013 and 12/30/2013 is certified. 2. The prospective request for 6 acupuncture sessions between 09/11/2013 and 12/30/2013 is certified.
- Also reviewed was a second Authorization retracting billed charges sent to Provider dated November 15, 2013. Authorization was very specific stating: 1. The prospective request for 1 set of transforaminal epidural steroid injections on the right at L4, L5 and S1 between 10/23/2013 and 01/12/2014 is non-certified. 2. The prospective request for 1 prescription of Hydrocodone/APAP 10/325 mg #90 between 10/23/2013 and 01/12/2014

is certified. 3. The prospective request for 6 acupuncture sessions between 10/23/2013 and 01/12/2014 is non-certified.

- Provider submitted billed charges for date of service 12/11/2013 which falls within the date range of non-certified procedures.
- Based on documentation received, Claims Administrator was correct to deny charges and therefore no reimbursement if warranted for codes 64483, 64484-RT and 64484-RT-59

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 64483, 64484-RT and 64484-RT-59 is not recommended.**

Date of Service: 12/11/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64483-RT	\$6000.00	\$0.00	\$6000.00	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended
64484-RT	\$3000.00	\$0.00	\$3000.00	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended
64484-RT-59	\$3000.00	\$0.00	\$3000.00	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended

Copy to:

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