

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 9, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0000258	Date of Injury:	12/09/2010
Claim Number:	[REDACTED]	Application Received:	02/24/14
Claims Administrator:	[REDACTED]		
Date Assigned:	4/7/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	62290, 62290-59, 72295-26, and 72295-26		

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 \$195.00 for the review cost and \$569.40 in additional reimbursement for a total of \$764.40. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$764.40 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, MD, MPH  
Medical Director

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

## 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 62290, 62290-59, 72295-26, and 72295-26
- Claims Administrator denied codes indicating on the Explanation of Review “Payment based on individual pre-negotiated agreement for this specific service” and “Number of services exceed Utilization Agreement”
- Procedure Report submitted documents two lumbar discograms were performed at levels L4-5 and L5-S1 along with fluoroscopy for spinal injections. A separate Discography Worksheet was also submitted to interpret findings as well as views from the radiological scans for both levels.
- Provider’s RFA states CT discogram lumbar 4/5 and L5/S1
- Utilization Review dated 1/29/2013 states “1. Recommend prospective request for 1 epidural steroid injection to the lumbar spine between 1/28/2013 and 4/29/2013 be certified”
- Utilization Review dated 2/21/2013 states “1. Recommend prospective request 1 CT scan of the L4-L5 and L5-S1 level using the L4-L5 as the control level (One Call Medical) between 1/17/2013 and 5/22/2013 be certified”
- CPT 62290 - injection procedure for discography, each level; lumbar. CPT 72295 - Discography, lumbar, radiological supervision and interpretation.
- Based on information reviewed, reimbursement of discograms is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 62290, 62290-59 and 72295-26, 72295-26 is recommended.

<b>Date of Service: 3/29/2013</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
62290	\$2663.00	\$0.00	\$214.20	1	N/A	\$214.20	<b>DISPUTED SERVICE:</b> Allow reimbursement \$214.20
62290-59	\$2663.00	\$0.00	\$214.20	1	N/A	\$214.20	<b>DISPUTED SERVICE:</b> Allow reimbursement \$214.20
72295-26	\$600.00	\$0.00	\$352.50	1	N/A	\$70.50	<b>DISPUTED SERVICE:</b> Allow reimbursement \$70.50
72295-26	\$600.00	\$0.00	\$352.50	1	N/A	\$70.50	<b>DISPUTED SERVICE:</b> Allow reimbursement \$70.50

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