

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 21, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001659	Date of Injury:	01/12/2010
Claim Number:	[Redacted]	Application Received:	11/03/2014
Claims Administrator:	[Redacted]	Assignment Date:	12/04/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64483-RT, & 64483-LT		

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 \$250.00 for the review cost and \$24.45 in additional reimbursement for a total of \$274.45. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$274.45 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,

[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
- MUE
- AMA CPT 2014

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 remuneration for 64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level, Modifiers RT (Right) and LT (Left), performed on 08/20/2014.
- The Claims Administrator denied the service **64483- LT** stating, “The Medically Unlikely Edits have been applied to this procedure.”
- Documentation indicates procedure performed bilaterally at “each level.” However, only one level, L5, is documented.
- Medically Unlikely Edits indicate a value “1” unit may be performed.
- CPT 2014 code description indicates “single level.”
- Based on the aforementioned guidelines and documentation, additional reimbursement cannot be recommended for CPT 64483-LT
- **CPT 64483-RT** §9789.30 “For services rendered on or after January 1, 2013 and before September 1, 2014: APC payment rate x 1.20 workers’ compensation multiplier for hospital outpatient departments and **0.80** workers’ compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(aa).”
- UB-04 indicates Place of Service as “831.”
- Service performed prior to September 1, 2014.

- Wt. 8.51 x Wage 80.78 x WC Multi. 0.80 = \$549.95
- Provider Reimbursed \$525.50
- Provider seeking \$549.33 as indicated on IBR application
- Additional reimbursement of \$24.45 is warranted for CPT 64483-RT.
- No PPO Contract Indicated

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of 64483-RT is warranted and 64483-LT is not warranted.

Date of Service: 08/20/2014							
Ambulatory Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
64483-RT	\$6,000.00	\$525.50	\$549.33	N/A	1	\$549.33	OMFS – Reimbursed Amount = \$24.45 Due Provider
64483-LT	\$6,000.00	\$0.00	\$274.67	N/A	1	\$0.00	Refer to Analysis

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