

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 29, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000209	Date of Injury:	02/04/2005
Claim Number:	[Redacted]	Application Received:	02/17/2015
Claims Administrator:	[Redacted]		
Date Assigned:	3/9/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	01936-QZ-QS		

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 \$163.86 in additional reimbursement for a total of \$358.86. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$358.86 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: Enter contract rates if available
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: Enter the MFS Anesthesia Ground Rules and Fee Schedule, AMA CPT.

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 code 01936-QZ-QS for date of service 9/5/2014.
- Claims Administrator denied code indicating on the Explanation of Review “Service/item included in the value of other services per CCI edits. Related service could be on a separate bill” and “Documentation does not support the level of service billed. Reimbursement based on a code supported by the submitted description and documentation.”
- **Modifier -QZ CRNA service: without medical direction by a physician**
- **Modifier –QS Monitored Anesthesia Care (MAC)**
- Pursuant 1/1/2014 Anesthesia Services NCCI Policy Manual for Medicare Services: D.- Monitored Anesthesia Care (MAC) may be performed by an anesthesia practitioner who administers sedatives, analgesics, hypnotics, or other anesthetic agents so that the patient remains responsive and breathes on his own. MAC provides anxiety relief, amnesia, pain relief, and comfort. MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and the recognition and treatment of any adverse changes. CMS recognizes this type of anesthesia service as a payable service if medically reasonable and necessary.

- Provider submitted the Anesthesia Record recording Anes start and stop time along with anesthesia monitored. Also reviewed was the Medical Necessity for Anesthesia describing the necessity for MAC with IV Sedation.
- Reimbursement Calculation Factors:
 - Anesthesia Time: 9:33 – 9:50
 - Anesthesia Base Units for Code 01936 - 5 units
 - Anesthesia Time Calculated at 15 minute increments
 - Anesthesia Time Units = 1 unit (15 minutes)
 - Total Units = 6 units
 - Anesthesia Conversion Factor = \$33.819
 - Five percent reduction applied to Anesthesia Conversion Factor = \$32.13
 - Reimbursement calculation = Anesthesia Units x Anesthesia Conversion Factor = Allowed = 6 x 32.13 x .85 = \$163.86
- Based on information reviewed, reimbursement of 01936-QZ-QS is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 01936-QZ-QS is recommended.

Date of Service: 9/5/2014						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
01936-QZ-QS	\$490.00	\$0.00	\$212.75	17	\$163.86	DISPUTED SERVICE: Allow reimbursement \$163.86

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