

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

May 26, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000276	Date of Injury:	03/26/2004
Claim Number:	[REDACTED]	Application Received:	02/27/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	3/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	00630-QZ		

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,

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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS 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 reimbursement of code 00630-QZ
- Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.12.6, 9789.15.4, 9789.16.1, 9789.17.1, and 9789.19, pertaining to Physician Fee Schedule in the Official Medical Fee Schedule, are adjusted to conform to the final rule of December 10, 2013, published in the Federal Register (Vol. 78 FR 74230), titled, "Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014" (CMS-1600-FC), which changes the Medicare payment system.
- Claims Administrator reimbursed \$95.33 indicating on the Explanation of Review "The documentation doesn't support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing"
- Provider billed code 00630-QZ - Anesthesia for procedures in lumbar region; not otherwise specified
- Operative Procedure Report submitted documents the cervical epidural steroid injection under fluoroscopy, epidurography. Nowhere in the report does the provider mention a lumbar procedure. Code 00630 is used when a lumbar procedure is taking place.

- Based on information reviewed, additional reimbursement for code 00630-QZ is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 00630 is not recommended.

<b>Date of Service:</b> 6/24/2013						
<b>Anesthesia Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
00630-QZ	\$420.00	\$95.33	\$324.67	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See analysis.

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