

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 21, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000284	Date of Injury:	03/19/2014
Claim Number:	[REDACTED]	Application Received:	02/27/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	3/25/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	00630-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 \$182.62 in additional reimbursement for a total of \$377.62. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$377.62 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: PPO Discount 10%
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: 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 disputing the denial for anesthesia services provided during a bilateral L5-S1 facet joint injection. Provider billed CPT 00630 QZ QS at \$900.00.
- 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.
- Code 01992 was established to describe and report anesthesia services for diagnostic or therapeutic nerve blocks and injections with the patient in the prone or other positions, when a block or injection is performed by a different provider.
- Based on review of the operative report: Operation Performed was a Bilateral L5-S1 facet joint injection; fluoroscopy for needle placement.
- CRNA provided the anesthesia services.

- Indication for Anesthesia, anesthesia was requested for control of patient movement during needle placement and patient's safety and comfort and monitoring of the patient while in the prone position.
- Reimbursement for anesthesia services recommended based on CPT 01992(Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position).
- The allowance is to be calculated based on the PPO Contract and therefore the 10 percent discount is applicable.
- Reimbursement Calculation Factors:
 - Anesthesia Time: 10 minutes
 - Anesthesia Base Units for Code 5 units
 - Anesthesia Time Calculated at 15 minute increments
 - Anesthesia Time Units = 1 unit (15 minutes)
 - Total Units 6 units
 - Anesthesia Conversion Factor = \$33.8190
 - Reimbursement calculation = 6 x 33.8190 =\$202.91 less 10% PPO Discount = \$182.62
 - Based on information reviewed, reimbursement of code 01992 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 11/13/2014						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
01992	\$900.00	\$0.00	\$299.95	10	\$182.62	DISPUTED SERVICE: Allow reimbursement \$182.62

Copy to:

████████████████████
 ████████████████
 ████████████████

Copy to:

██
 ██
 ██