

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 26, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001486	Date of Injury:	04/26/2012
Claim Number:	[REDACTED]	Application Received:	08/31/2015
Assignment Date:	09/17/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/12/2013 – 08/12/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	00300-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: 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 \$11.46 in additional reimbursement for a total of \$206.46. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$206.46** 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, M.D., M.P.H.
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
- PPO Contract

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 additional remuneration for 00300-QS - QZ Anesthesia Services performed on 08/12/2013.**
- EORs reflect the Claims Administrator's reimbursement rational as follows:
 - The allowance is based on the anesthesia services performed by a CRNA not under medical direction of an anesthesiologist.
 - The procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing.
- Response to Second EOR indicates 00300 reimbursed as 01995 local anesthesia to upper/lower extremity Re-evaluation Control 15008464, Original EOR Control 15008023, indicates above rational.
- CRNA Report indicates "with sedation," which is not a "local" anesthetic as indicated by re-assigned (local) anesthesia code "01995." Additionally, the CRNA states, "due to patient's inability to "stay still," "more extensive anesthesia," was required.
- Date of Service 8/12/2013; **CCR § 9789.11**. Physician Services Rendered on or after July 1, 2004.8 (d)(2) To determine the maximum allowable reimbursement for anesthesia services (CPT Codes 00100 through 01999) rendered after January 1, 2004, the following formula is utilized: (basic value + modifying units (if any) + time value) × (conversion factor × **0.95**) = maximum reasonable fee.
 - Abstracted information from Anesthesia Reports indicates the following equations:
 - Basic Value = 5
 - Modifying Units = 1 (15 min reflected in report)
 - OMFS Conversion Factor for 2013 = **34.5**
- Submitted Contractual Agreement, entitled "Appendix A," section "D," indicates Worker's Compensation reimbursement "**shall not exceed 85%**" of the maximum allowable of "state law or regulations."
 - Contractual Agreement does not indicate a special separate provision for CRNA or Assistants when treatment provided to the Occupationally Ill or Injured.
- Anesthesia Reimbursement as follows:
 - **6 x 34.5 x 0.95 = \$196.65 (OMFS) x PPO = Allowable Amount**
- **Based on the aforementioned documentation and guidelines, reimbursement for**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE 00300-QS-QZ

Date of Service: 08/12/2013 Anesthesia						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
00300	\$420.00	\$155.69	\$40.99	1	\$167.15	PPO Contract – Reimbursed Amount \$11.46 Due Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]