

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 28, 2015



IBR Case Number:	CB15-0001518	Date of Injury:	11/16/2013
Claim Number:	[REDACTED]	Application Received:	09/01/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/02/2014 – 12/2/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	23412-LT, 64415-59LT, and 93005		

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 \$239.74 in additional reimbursement for a total of \$434.74. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$434.74 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

MAXIMUS FEDERAL SERVICES, INC.

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Medical Director

cc:



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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital Fee Schedule

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 reimbursement for CPT 23412-LT, 64415-59-LT and 93005 for date of service 12/2/2014.**
- Provider billed the procedure codes as part of hospital service on a UB04 with bill type 131.
- Claims administrator issued reimbursement in the amount of \$5,122.26 (385.55 PPO discount) for CPT 23412-LT, \$36.74 (2.76 PPO discount) for CPT 93005-59 and denied reimbursement for CPT 64415-59.
- CPT 23412-LT: Provider documentation indicated a PPO allowance of 93% of OMFS. In review of the EOR, CPT 23412 was reimbursed based on the OMFS allowance minus a PPO discount of 7%.
- CPT 23412: $52.0371 \text{ (RW)} \times 87.33 \text{ (Adjusted CF)} \times 1.212 = \$5,507.81 - 385.55 \text{ (7\% PPO discount)} = \$5,122.26$. No additional reimbursement is recommended.
- CPT 93005: No additional allowance recommended based the rules and regulations sited below:
 - Title 8, CCR 9789.32(a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014.
 - (c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for

a facility fee payment and are not bundled in the APC payment rate for services in (a) will be determined as follows:

- (1)(A) For services rendered before September 1, 2014, the maximum allowable hospital outpatient facility fees for professional medical services which are performed by physicians and other licensed health care providers to hospital outpatients shall be paid according to Section 9789.10 and Section 9789.11.
- (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
- Provider was reimbursed \$36.74 for CPT 93005-59. OMFS RBRVS for date of service 12/2/2014 is \$10.05.
- CPT 64415-59-LT: Injection, anesthetic agent; brachial plexus, single
- Per coding guidelines (CPT Assistant), Codes for procedures commonly used in the management of postoperative pain include 62318 and 62319 (both introduced in CPT 2000) for continuous epidural analgesia and the series of codes for somatic nerve blocks (64400- 64450).
 - It is appropriate to report pain management procedures, including the insertion of an epidural catheter or the performance of a nerve block, for postoperative analgesia separately from the administration of a general anesthetic.
 - When general anesthesia is administered and these injections are performed to provide postoperative analgesia, they are separate and distinct services and are reported in addition to the anesthesia code. Whether the block procedure (insertion of catheter; injection of narcotic or local anesthetic agent) occurs preoperatively, postoperatively, or during the procedure is immaterial.
- The Peripheral Nerve Block Record documented the block was for “Post-operative pain management.” Operative Report indicated “General Anesthesia was performed. Interscalene block performed by the anesthesiologist.”
- The medical record substantiated the billed code 64415-59-LT, reimbursement is recommended.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: CPT 64415-59-LT.

Date of Service 12/02/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
23412-LT	\$ 20045.00	\$ 5122.26	\$ 0.00	N/A	\$5122.26	DISPUTED SERVICE: See Analysis.
93005	\$297.00	\$36.74	0.00	N/A	\$10.05	DISPUTED SERVICE: See Analysis.
64415-59-LT	\$1623.00	\$0.00	239.74	N/A	\$239.74	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$239.74 recommended

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