

**MAXIMUS FEDERAL SERVICES, INC.**

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

November 13, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001921	Date of Injury:	04/18/2012
Claim Number:	[Redacted]	Application Received:	10/19/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	08/17/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	61070 and 77003-26		

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 \$136.91 in additional reimbursement for a total of \$331.91. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$331.91 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: N/A
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

## 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 remuneration for codes 61070 and 77003-26 on date of service 8/17/2015.
- Claims Administrator denied codes indicating on the Explanation of Review “The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing” and “This service requires prior authorization and none was identified”
- Provider billed codes on a CMS 1500 with Place of Service 24. Codes billed include:
  1. 61070 - Puncture of shunt tubing or reservoir for aspiration or injection procedure
  2. 77003 - Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid).
- Utilization Review documentation dated August 12, 2015 “Certify” 1 pump dye study at Provider’s Surgery Center.
- Procedure Note for date of service 08/17/2015 documents Intrathecal pump dye study performed.
- CPT Assistant Diagnostic Radiology documents: implanted pump catheter dye studies typically require an injection component and a radiologic supervision and interpretation

(RSI) component; therefore, it would also be appropriate for the physician performing the injection to report code 61070 to describe the injection service itself.

- CPT 61070 & 77003-26 are the most appropriate codes to bill services documented for date of service 8/17/2015 as no other code supports the injection component **AND** radiologic supervision and interpretation.
- Opportunity for Claims Administrator to Dispute Eligibility letter was sent on 10/20/2015. A response from Claims Administrator was not received for this review.
- Based on aforementioned documentation, reimbursement of 61070 and 77003-26 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 61070 & 77003-26

Date of Service: 08/17/2105					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
61070	\$460.00	\$0.00	\$460.00	\$91.00	<b>\$91.00 Due to Provider</b>
77003-26	\$300.00	\$0.00	\$300.00	\$45.91	<b>\$45.91 Due to Provider</b>

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