

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 26, 2015

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

IBR Case Number:	CB15-0000597	Date of Injury:	07/16/2014
Claim Number:	████████████████████	Application Received:	04/20/2015
Claims Administrator:	████████████████████		
Date Assigned:	5/16/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	64483, 64483-50, 76000-26-59, 72275-26-59, and 99144-59		

Dear ██████████

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 \$386.84 in additional reimbursement for a total of \$581.84. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$581.84 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: ██████████
████████████████████

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

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 denial of codes 64483, 64483-50, 76000-26-59, 72275-26-59, and 99144-59
- Claims Administrator denied codes indicating on the Explanation of Review “This charge is denied as the service was not authorized during the utilization review process.”
- Provider submitted his Request for Authorization for Medical Treatment which requested Procedure “LESI”.
- Claims Administrator Approved request with a signature and date of 9/17/14.
- Provider billed codes 64483, 64483-50, 76000-59, 72275-59 and 99144-59 all on a 1500 claim form.
- 99144- Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time
- 76000 -Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034
- 72275 - Epidurography, radiological supervision and interpretation
- Provider’s documentation does not support services listed, 99144, 76000 and 72275, and therefore reimbursement is not warranted.

