

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 26, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB4-0000117	Date of Injury:	03/29/2013
Claim Number:	[REDACTED]	Application Received:	08/12/2014
Claims Administrator:	[REDACTED]	Assignment Date:	03/30/2015
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	62311, 00630, 76499, 72100 x 12, 62311-59 and 76499-59		

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 \$250.00 for the review cost and \$197.97 in additional reimbursement for a total of \$447.97. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$447.97 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

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 62311, 00630, 76499, 72100 x 12, 62311-59 and 76499-59 In-Patient Provider Services performed 03/11/2014.**
- The Claims Administrator denied reimbursement based on the following rationale: "Payment Denied/reduced for absence of or exceeded referral."
- Authorization 2/26/2014 from Claims Administrator reflects the following procedures as **certified**:
 - Bilateral L4-5 Epidural Steroid Injection.
 - No Other Services Indicated or Implied.
- The Following Procedure Codes Performed on 03/11/2014 are **not** reflected on 2/26/2014 authorization:
 - 00630, Anesthesia spine cord surgery
 - 76499, Unlisted diagnostic radiographic procedure
 - 72100 x 12, Radiologic examination, spine, lumbosacral; 2 or 3 views
 - 76499-59, Unlisted diagnostic radiographic procedure
- Authorization 2/26/2014 from Claims Administrator reflects the following procedures as **certified**:
 - 62311 & 62311-59
- §9789.16.5(f) Multiple Procedures Including Bilateral Surgeries: If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.

- The aforementioned Authorization supports reimbursement for 62311 & 62311-59 does not support reimbursement for 00630, 76499, 72100 x 12, 62311-59 and 76499-59.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97799 - 86

Date of Service: 03/11/2014							
Physician Services – In Patient							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
62311	\$1,122.00	\$0.00	\$119.99	N/A	1	\$0.00	Refer to Analysis
62311-59	\$1,122.00	\$0.00	\$119.99	N/A	1	\$197.97	Refer to Analysis
00630	\$360.00	\$0.00	\$360.00	N/A	1	\$0.00	Refer to Analysis
76499	\$400.00	\$0.00	\$400.00	N/A	1	\$0.00	Refer to Analysis
76499 - 59	\$400.00	\$0.00	\$400.00	N/A	1	\$0.00	Refer to Analysis
72100 x12	\$732.24	\$0.00	\$432.24	N/A	12	\$0.00	Refer to Analysis

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