

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 26, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000026	Date of Injury:	08/11/2014
Claim Number:	[REDACTED]	Application Received:	12/21/2015
Assignment Date:	01/22/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/08/2015 – 07/08/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	62355-59		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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
- OMFS

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 62355-Removal of spinal catheter service provided to Injured Worker on date of service 07/08/2015.**
- The Claims Administrator denied reimbursement with the following rationale: “Charges are unrelated to Industrial Injury, “and “not the liability of the Workers’ Compensation Carrier.”
- CMS 1500, Place of Service 21, Bill Type Provider.
- CMS 1500 indicates diagnosis 724.4— Lumbosacral neuritis nos.
- CPT 62355-59 performed during “subsequent” hospital visit on 07/08/2015.
- One Page Authorization 09/11/2015, signed by the Claims Administrator indicates the following: “Recommend retrospective request for “**1 for reconsideration: Retrospective review for in-hospital Acute Pain Consultation related to lumbar spine injury retrospective in-hospital Acute Pain Consult between 7/7/2015 and 7/11/2015, as certified,**” RFA date “09/02/2015.”
 - Initial RFA referred to as “36480” not submitted for IBR, **unable to review Initial Request for services.**
 - Authorization does not indicate treatment plan as “certified.”
 - Authorization does not indicate follow-up care as “certified.”
 - Authorization does not indicate “Consult and treat.”
 - Authorization indicates 1 (one) Acute Pain Consultation as “certified.”
- The “subsequent” visit of 07/08/2015 was not authorize; EOR indicates service denied by the Claims Administrator. CPT 62335-59, performed during the denied subsequent service and requires authorization for reimbursement.
- Provider indicates there is not a Contractual Agreement in place with the Claims Administrator for Workers’ Compensation Injuries.”
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 01/06/2016; response not yet received.
- Authorization dated May 19, 2015, signed by the Claims Administrator indicates certified services relating to in-patient stay post lumbar fusion. This authorization is specific to the standard treatment of care for the authorized surgery and does not represent an authorization for services not normally performed during the operative and postoperative period. Additionally, the authorized dates indicate between “05/15/2015 and -06/29/2015.” The aforementioned 09/11/2015 retroactive authorization reflects **1 (one) consultation** for pain as “certified.” Authorization for “subsequent” or spinal catheter removal services relating to the Initial Consultation are not indicated.
- **Authorization** for dates of service **07/08/2015, not received for IBR.**
- Initial Consultation, 99223 is indicated as certified and, based on the documentation presented, is eligible for reimbursement, however, 99223 is not indicated as a disputed code on this IBR and reimbursement cannot be recommended.
Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 62355-59.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 62355-59

Date of Service: 07/08/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
62355-59	\$300.00	\$0.00	\$300.00	1	\$0.00	OMFS

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
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