

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 2, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000161	Date of Injury:	12/24/2010
Claim Number:	[Redacted]	Application Received:	02/03/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	10/06/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64510		

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 \$620.53 in additional reimbursement for a total of \$815.53. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$815.53 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 of 64510 performed on 10/06/2015.
- Claims Administrator denied service indicating on the Explanation of Review “This service appears to be unrelated to the patients diagnosis”
- Provider billed diagnosis G90.511 on UB-04 with bill type 837.
- G90.511: Complex regional pain syndrome of right upper limb.
- Provider’s Operative Report documents “Stellate Ganglion Block “fluoroscopy was used to identify the right C-6 transverse process” and “spinal needle was advanced toward the medial aspect of the C-6 transverse process...”
- RFA dated 08-28-2015 documents “Procedure Requested: Stellate Ganglion Block on the Right Side under Fluoroscopy and monitored anesthesia care to be done at Oasis Surgery Center”
- Communication from Claims Administrator to Provider dated September 25, 2015 showing authorization for “Approved Service Description: Right Stellate Ganglion Block under Fluoroscopy and monitored anesthesia care”

- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- Communication from Claims Administrator dated September 25, 2015 is contract in nature.
- Based on information reviewed and guidelines, reimbursement of 64510 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 64510

Date of Service: 10/06/2015					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
64510	\$10,615.80	\$0.00	\$620.53	\$620.53	\$620.53 Due to Provider

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]