

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 17, 2016

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB16-0000249	Date of Injury:	10/13/1997
Claim Number:	[Redacted]	Application Received:	02/17/2016
Assignment Date:	03/09/2016		
Claims Administrator:	[Redacted]		
Date(s) of service:	08/05/2015 – 08/05/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64883 – Rt. and 64883 – Lt.		

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 \$660.28 in additional reimbursement for a total of \$855.28. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$855.28** 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
- 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 additional remuneration for bilateral 64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level, performed 08/05/2015.**
- The Claims Administrator's reimbursement rational indicates as per MPPR and "non-facility" site of service.
- Bill Type 831, UB-04.
- Provider's facility is a surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248 with Licensing Period reflected as "4/26/2013 - 4/25/2016."
- Effective December 1, 2014, For services rendered on or after December 1, 2014, section 9789.31, subsections (a) and (b) are amended to incorporate by reference selected sections of the updated calendar year 2014 version of CMS' hospital outpatient prospective payment system (HOPPS) published in the Federal Register on December 10, 2013, the updated fiscal year **2014** versions of CMS' IPPS Tables 2, 4A, 4B, 4C, and 4J in the final rule of August 19, 2013 and associated rules and notices to the IPPS final rule, respectively.
- **CCR § 9789.16.5** Surgery – Multiple Surgeries and Endoscopies (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.
- **Based on the aforementioned documentation and guidelines, Ambulatory Services reimbursement is indicated for 64883 – Rt., 64883 – Lt.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 64883 – Rt., 64883 – Lt.**

Date of Service: 08/05/2015 HOPPS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
64883 – Rt., 64883 – Lt.	\$2,476.00	\$269.72	\$661.07	1	\$930.00	<b>\$660.28 Due Provider Refer to Analysis</b>

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]