

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 13, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000104	Date of Injury:	03/23/1998
Claim Number:	[Redacted]	Application Received:	01/22/2015
Claims Administrator:	[Redacted]		
Assigned Date:	2/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	62368 & 99215-25		

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 \$43.61 in additional reimbursement for a total of \$238.61. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$238.61 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:
- 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 99215-25 and 62368. Provider is requesting a total of \$173.02 for the two codes 99215-25 and 62368.
- Claims administrator denied code 99215-25 indicating on the Explanation of Review “We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible.”
- Documentation submitted for review included Provider’s Pump Progress Report, Intrathecal Pump Maintenance and Administrator Record and Session Data Report.
- Documentation does not support a significant, separately identifiable evaluation and management service by the same physician on the same day as the pump refill and maintenance. Therefore, no reimbursement is warranted for 99215-25.
- Claims administrator also denied code 62368 indicating on the Explanation of Review “Report necessary for reimbursement. Please resubmit with appropriate report.”
- Code 62368 - Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
- Documentation included the Session Data Report which reports the evaluation of reservoir status, alarm status and drug prescription.
- Based on information reviewed, reimbursement for code 62368 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 62368 is recommended.

Date of Service: 3/12/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99215-25	\$350.00	\$0.00	\$129.41	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.
62368	\$500.00	\$0.00	\$43.61	1	N/A	\$43.61	DISPUTED SERVICE: Allow reimbursement \$43.61

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