
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 14, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000196	Date of Injury:	08/21/2009
Claim Number:	[REDACTED]	Application Received:	02/11/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/22/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64999 and 64999-50 x 2		

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, 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 for unlisted procedure, nervous system codes 64999 and 64999-50 x 2 on date of service 06/22/2015
- Claims Administrator reimbursed \$401.37 with indication “The value of this procedure is based on 100% of 64493-50, which appears equal in scope and complexity to services rendered L5-S1”
- CCR § 9789.12.4. “By Report” -Reimbursement for Unlisted Procedures/Procedures Lacking RBRVUs. (c) In determining the value of a By Report procedure, consideration may be given to the value assigned to a comparable procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed.
- 64493: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
- Documentation submitted included Provider’s Procedure which states “posterior fusion hardware injection at L5 and S1 bilaterally with cinefluoroscopy and fluoroscopically guided needle placement” and “The procedure was performed at L5 and S1 bilaterally. 4 Bolts were injected”

- Certification Recommendation decision date June 16, 2015 from Claims Administrator documents “Certified: Hardware Injection; # of Injection: 1; Body Part: Lumbar and/or Sacral Vertebrae”
- § 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.
- Documentation dated June 16, 2015 is contract in nature which “Certified” 1 injection. Documentation from Provider shows bilateral injection at L5 and S1. Claims Administrator reimbursed Provider based on a comparable code with increased bilateral modifier value of 150%.
- Based on documentation reviewed and guidelines, additional reimbursement for 64999 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 64999 and 64999-50 x 2

Date of Service: 06/22/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64493-50	\$2549.00	\$401.37	\$2047.52	N/A	\$401.37	Refer to Analysis

[REDACTED]

[REDACTED]