

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 4, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001818	Date of Injury:	09/22/2010
Claim Number:	[Redacted]	Application Received:	11/24/214
Claims Administrator:	[Redacted]	Assignment Date:	12/12/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64483-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 \$250.00 for the review cost and \$549.33 in additional reimbursement for a total of \$799.33. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$799.33 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
- Official Medical Fee Schedule
- American Medical Association CPT 2014

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 full remuneration for 64483-LT Foramen Epidural of Lumbar Spine performed on 08/22/2014.**
- Claims Administrator denied claim with the following rationale: “Payment denied/reduces for absence of, or exceeded, pre-certification/authorization.”
- Authorization dated 8/7/2014 indicates: “Your request for esi to L4-L4 is approved.” CPT Code not specified.
- AMA CPT Code Description for standard Epidural Steroid Injection: CPT 62311 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal).
- CPT 64483 AMA CPT Code Description: Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level.
- The procedure report indicates the Provider accurately documented the actual procedure performed, CPT 64483.
- The difference between the two modalities, CPT 62311 and 64483, is essentially technique and guidance; one with imaging and one without. However, the end result of each arrive at the same conclusion. Additionally, the weight of each procedure is equal meaning, the value (fee) is the same.

