INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 15, 2014

Dear [Provider Name],

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 $49.62 in additional reimbursement for a total of $299.62. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $299.62 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,

[Provider Name]

cc: [Practitioner Name]
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
  - Other: OMFS Physician Services

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 97002-59 and 97113-59.
- Based on the NCCI edits that exist, Modifier Indicator ‘1’ states with a proper modifier appended to the correct code, and documentation supports the necessity for the procedure, then the Edit may be overridden.
- CPT 97113-59 and 97002-59 were denied by Claims Administrator indicating on the Explanation of Review “Per CCI Edits, the value of this procedure is included in the value of the Mutually Exclusive Procedure.”
- Generally CPT codes 97113 and 97150 are not billed together. Pursuant to Labor Code section 5307.27, MTUS shall address, at a minimum, “the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases.”
- Provider failed to submit the documentation necessary to support CPT 97113-59 on date of service 05/15/2014 and therefore, reimbursement is not warranted.
• Provider also was denied CPT 97002-59. Submitted documentation shows that a re-evaluation was performed which included subjective and objective elements, assessment and plan to discharge patient.
• Based on information reviewed, Claims Administrator was incorrect to deny CPT 97002-59 and therefore, reimbursement is warranted for CPT 97002-59.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Based on information received, reimbursement of code 97002-59 is warranted.

<table>
<thead>
<tr>
<th>Date of Service: 5/15/2014</th>
</tr>
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<tbody>
<tr>
<td><strong>Physician Services</strong></td>
</tr>
<tr>
<td><strong>Service Code</strong></td>
</tr>
<tr>
<td>97113-59</td>
</tr>
<tr>
<td>97002-59</td>
</tr>
</tbody>
</table>

National Correct Coding Initiative information:

<table>
<thead>
<tr>
<th>File</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Version Number: 20.1 4/1/2014-6/30/2014</td>
<td>97150</td>
<td>97002</td>
<td>Allow Modifier</td>
</tr>
</tbody>
</table>

Copy to:

[Redacted]

Copy to:

[Redacted]