

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001061	Date of Injury:	02/18/2014
Claim Number:	[Redacted]	Application Received:	07/30/2014
Claims Administrator:	[Redacted]	Assignment Date:	09/23/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	97002-59		

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 \$329.98 in additional reimbursement for a total of \$579.98. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$579.98 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,

[Redacted]
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: PPO Contract 5% Discount
- National Correct Coding Initiatives
- Other: OMFS Physician Services, CPT Assistant, General Information and Instructions (8CCR §9789.11(a)(1))

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 CPT 97002-59 for multiple injured workers on separate dates of service.
- Claims Administrator has denied CPT code 97002-59 for eight (8) different injured workers on eight (8) separate dates of service. Reason for denied CPT code 97002 is indicated on the Explanation of Review as “In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), Component Code of Comprehensive Medicine, Evaluation and Management Services procedure (90000-99999) has been disallowed.”
- Services billed for all injured workers were submitted on a CMS’ 1500 form for Physician Services in an office setting not an outpatient hospital or ambulatory center. Therefore, Outpatient Services does not apply to these cases in review.

- According to NCCI edits, 97002, is not “generally” reported with some of the other CPT codes billed. CCI Edits also states “*If Modifier Indicator=1, there may be occasions where both codes are payable, see [NCCI Chapter I Section E](#)*”; Section E Modifiers and Modifier Indicators: Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Other modifiers: 27, 59, 91
- Modifier 59: “Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters.
- Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. **Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.**
- Pursuant to CPT Assistant Physical Medicine and Rehabilitation Services, 97002 is strictly for the purposes of a comprehensive reevaluation needed to support medical necessity for further care. This code may only be used in addition to other services, if significant enough to report, and require separate effort from the provider in addition to other procedure(s). 97002 should be used when the physical therapy reevaluation is not an inclusive component of the other procedure(s) being provided.
- Title 8 California Code of Regulations Physical Medicine Physical therapist Assessment and Evaluation codes and test and measurement procedures are not included in the multiple procedures calculation or in the "no more than four in one visit."
- Provider states a 5% negotiated discount rate is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information received for each case submitted, reimbursement of code 97002 is outlined in the table below.

Date of Service: Multiple dates of service for CPT code 97002-59 –Physical Therapy Re-evaluation						
Physician Services						
Date of Service & Injured Worker	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Case Details	Notes
3/19/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	Documentation for re-evaluation was submitted	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.
3/11/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$0.00	Documentation submitted shows Daily Therapy Treatment Note not a Re-evaluation.	DISPUTED SERVICE: No reimbursement recommended as documentation submitted does not support code 97002 billed.
3/7/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	Documentation for re-evaluation was submitted	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.
2/17/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	Documentation for re-evaluation was submitted	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.
1/10/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	Documentation for re-evaluation was submitted	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.
3/14/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	Documentation for re-evaluation was submitted	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.
2/11/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$0.00	Documentation submitted does not state a re-evaluation was performed.	DISPUTED SERVICE: No reimbursement recommended as documentation submitted does not support code 97002 billed.
1/8/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.
3/11/14 [REDACTED]	\$49.62	\$0.00	\$49.62	\$47.14	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.	DISPUTED SERVICE: Allow reimbursement \$47.14 per PPO discount.

National Correct Coding Initiative information: For all codes listed, a Modifier Indicator ‘1’ was noted in all cases of Active CCI Edits.

File	Column 1	Column 2	Modifier
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97140, 97530	97002	Modifier Allowed -59 Date of service: 3/19/14
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97112, 97530	97002	Modifier Allowed -59 Date of service 3/11/14
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97112, 97530	97002	Modifier Allowed -59 Date of service 3/7/14
Physician Version Number: 20.0 1/1/14-3/31/14	97112, 97535	97002	Modifier Allowed -59 Date of service 2/17/14
Physician Version Number: 20.0 1/1/14-3/31/14	97026, 97110, 97140	97002	Modifier Allowed -59 Date of service 1/10/14
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97530	97002	Modifier Allowed -59 Date of service 3/14/14
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97140, 97530	97002	Modifier Allowed -59 Date of service 2/11/14
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97112, 97140	97002	Modifier Allowed -59 Date of service 1/8/14
Physician Version Number: 20.0 1/1/14-3/31/14	97110, 97112, 97140	97002	Modifier Allowed -59 Date of Service 3/11/14

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