

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001147	Date of Injury:	02/10/2009
Claim Number:	[REDACTED]	Application Received:	08/15/2014
Claims Administrator:	[REDACTED]	Assignment Date:	09/24/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97032 and 97124		

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,

[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:
- 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 97124-59 and 97032
- Claims Administrator denied codes indicating on the Explanation of Review “The charge exceeds the fee-scheduled physical therapy time limit of 60 minutes per visit.”
- Provider billed 98941 along with 97124 on date of service 01/08/2014. Based on the NCCI edits that exist on code 97124, generally codes 98941 and 97124 are not reported together. However, Modifier Indicator column shows ‘1’ which states if the proper modifier is appended to the correct code then the edit may be overridden. Provider appended modifier -59.
- Modifier 59: “Distinct Procedural Service: 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.
- CPT 97124 – Massage Therapy. Provider failed to submit any documentation to support code 97124 and therefore, no reimbursement is warranted for 97124.

- Provider also billed code 97032 – Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes. Claims Administrator denied code stating it exceeded the 60 minutes per visit.
- 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 any documentation necessary to support CPT 97032 on date of service 01/08/2014.
- Based on information received, Claims Administrator was correct to deny CPT codes 97124-59 and 97032. Therefore, no reimbursement is recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information in this review, no reimbursement of codes 97124 and 97032 is warranted.

Date of Service: 1/8/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
97124-59	\$31.13	\$0.00	\$31.13	1	N/A	\$0.00	DISPUTED SERVICE:
97032	\$22.69	\$0.00	\$22.69	1	N/A	\$0.00	DISPUTED SERVICE:

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.0 1/1/2014-3/31/2014	98941	97124	Allow Modifier

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