

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 2, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001723	Date of Injury:	03/14/2014
Claim Number:	[Redacted]	Application Received:	11/17/2014
Claims Administrator:	[Redacted]		
Assigned Date:	12/12/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	97124-59 and 97032		

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 \$36.25 in additional reimbursement for a total of \$286.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$286.25 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 Discount 15%
- National Correct Coding Initiatives

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 codes 99214-25, 98942, 98943, 97124-59 and 97032. Both 97124-59 and 97032 are time based codes each 15 minutes per unit. Provider billed 1 unit for each code. 99214-25 indicates a separate procedure and time allowed is not included in the total time for procedures and modalities.
- Provider also billed appropriately according to NCCI Edit rules for code 97124-59 and submitted documentation to support the use of code 97124 in the Treatment report submitted.
- Under the new MPPR, full payment (100% of listed Practice Expense, Work, and Malpractice Expense) is made for the code with the highest Practice Expense value. For subsequent procedures, the Practice Expense component is reduced 50%, and the Work and Malpractice Expense components are paid at 100%. Title 8, CCR §9789.15.4
- Based on information reviewed, reimbursement of codes 97124-59 and 97032 is warranted.
- A PPO discount of 15% was taken from claims administrator and shall be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 97124-59 and 97032 is recommended.

Date of Service: 08/08/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
97124-59	\$31.31	\$0.00	\$31.31	1	N/A	\$26.61	DISPUTED SERVICE: Allow reimbursement \$26.61
97032	\$ 22.69	\$0.00	\$22.69	1	N/A	\$9.64	DISPUTED SERVICE: Allow reimbursement \$9.64

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