

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 29, 2015

[Redacted]
[Redacted]
[Redacted]
[Redacted]

***Consolidated Review for Multiple Injured Workers.**

IW1 = Injured Worker #1; IW2 = Injured Worker #2; IW3 = Injured Worker #3

IBR Case Number:	CB14-0001876	Date of Injury:	Multiple
Claim Numbers:	[Redacted] [Redacted]	Application Received:	12/08/2014
Claims Administrator:	[Redacted]	Assignment Date:	05/16/2014
Provider Name:	[Redacted]		
Employee Names:	[Redacted]		
Disputed Codes:	97113-59		

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: 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,

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

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 remuneration 97113 Aquatic Services performed on multiple dates for multiple Workers.
- Claims Administrator denied 97113 service stating: “Per CCI Edits, the value of the service is included within the value of another service performed on the same day.”
- CMS 1500 forms for all dates of service reflect additional service of 97150 Group Therapeutic Exercise.
- 97113 is paired to billed code 97150, Group Therapeutic Exercise.
- NCCI edits reveal 97150 is Colum 1 Code when billed with Colum 2 Code, 97113.
- Under certain circumstances, the paired codes in question may be unbundled with the use of modifier -59 provided the “two procedures of a code pair edit are performed in **different timed intervals** even if sequential during the same patient encounter.”
- Documentation for dates each date of service in question reflect Aquatic documentation noting “1:1” supervision by Therapist.
- Documentation for each date of service in question reflect Group Therapy.
- Start and end times for the Aquatic (97113) and Group (97150) sessions could not be verified in terms of time. Specifically, if the procedures were performed at “different timed intervals (or sequentially or the during the same 15/30 min interval sessions),” as dictated by Modifier -59 Code Description.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines reimbursement for 97113 – 59 cannot be recommended.

Date of Service: 06/03/2014, 09/24/2014, 09/26/2014, 10/03/2014, 10/06/2014, & 10/10/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
97113 – 59 x 6	\$692.30	\$0.00	\$692.40	N/A	1	\$0.00	IW1, IW2, & IW3 Refer to Analysis
97150	N/A	N/A	N/A	N/A	N/A	N/A	Code Not In Dispute

Copy to:

██████████
 ██████████
 ██████████

Copy to:

██
 ██
 ██