

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 25, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001963	Date of Injury:	07/21/2011
Claim Number:	[REDACTED]	Application Received:	10/14/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	20999, 20999-51, 20999-51, 20999-51, and 99080		

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 \$1346.53 in additional reimbursement for a total of \$1596.53. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1596.53 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,

Paul Manchester, MD, MPH  
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 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 reimbursement of code 20999 and 20999-51 x 3 and denial of code 99080
- Claims administrator denied code 99080 indicating on the Explanation of Review “Reimbursement for this report is included with other services provided on the same day; therefore, a separate payment is not warranted.”
- The report submitted is not a reimbursable report as it is included in the services performed and therefore reimbursement is not recommended for code 99080.
- Provider also billed code 20999 - Unlisted procedure, musculoskeletal system, general.
- Documentation submitted included the provider’s Request for Authorization for “Three days of FRP-MUA procedures for the cervical, thoracic, lumbar and sacroiliac articulation and for right shoulder adhesive capsulitis”
- Claims administrator authorized FRP-MUA x 3 days (Cervical, Thoracic, Lumbar and Sacroiliac Articulations, Right shoulder adhesive capsulitis) to be performed at the provider’s center. No pre-negotiated rate or conditions on codes to be billed were found on the approved authorization.
- Claims administrator used comparable code 97140 to base reimbursement of code 20999. 97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

