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 25, 2015

[redacted]

IBR Case Number:	CB14-0001965	Date of Injury:	08/17/2011
Claim Number:	[redacted]	Application Received:	12/23/2014
Claims Administrator:	[redacted]		
Assigned Date:	1/23/2015		
Provider Name:	[redacted]		
Employee Name:	[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: 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 $147.18 in additional reimbursement for a total of $397.18. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $397.18 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]

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 5%
- 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 code 97113 x 2 units for two dates of service. Provider billed codes 97150 and 97113 on a CMS 1500 form.
- Claims administrator denied code indicating on the Explanation of Review "Service/item included in the value of other services per CCI edits. Related service could be on separate bill." No separate bill with code 97113 for these dates of service was submitted for this review.
- Per NCCI Edits mentioned, generally codes 97150 and 97113 are not billed together. However, Modifier Indicator column shows '1' which states if the correct code has an approved NCCI modifier appended, and documentation is submitted to support code used, then the edit may be overridden. Modifier -59 is an approved modifier and may be used to support billed code 97113. Provider billed CPT 97113 with modifier -59 on the CMS 1500 form for both dates of service.
- Documentation received included Daily Note/Billing Sheet which documents time spent direct one on one with a Physical Therapist as well as documented group session time.
- 97113 - Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises. Provider's notes are very clear and specific as time and exercise spent with 97113 and 97150.
- Based on information reviewed, reimbursement for code 97113 is warranted.
- Multiple procedure reduction is to be applied as well as a 5% PPO discount agreement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 97113-59 for both dates of service is recommended.

Dates of Service: 10/27/2014 and 10/31/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Procedure Reduction**	**Workers' Comp Allowed Amt.**	**Notes**
97113-59	$138.46	$0.00	$138.46	2	100%	$98.12	**DISPUTED SERVICE**: Allow reimbursement $98.12
97113-59	$138.46	$0.00	$138.46	2	50%	$49.06	**DISPUTED SERVICE**: Allow reimbursement $49.06

National Correct Coding Initiative information:

File	**Column 1**	**Column 2**	**Modifier Allowed?**
Physician Version Number: 20.3	97150	97113	Yes

Copy to:

[redacted]

Copy to:

[redacted]