

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 11, 2016



IBR Case Number:	CB16-0000235* *Amended from CB16-0000234	Date of Injury:	06/18/2015
Claim Number:	[REDACTED]	Application Received:	02/17/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/22/2015 – 07/02/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97140		

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 \$195.00 for the review cost and \$66.12 in additional reimbursement for a total of \$261.12. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$261.12** 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, M.D., M.P.H.
Medical Director



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
- OMFS

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 for 97140 Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes, for dates of service 6/22, 6/25, 6/29 and 7/2 2015.**
- The Claims Administrator's reimbursement rationale indicates: "Contract Rate."
- Medical records and UB-04 reviewed; 97140 indicates secondary procedure.
- Manual Therapy and Therapeutic Exercise documented.
- Contractual Agreement received for IBR documents "amount payable for services rendered to occupationally ill/injured employees shall be the amount payable under guidelines established under any State law or regulation pertaining to health care services rendered to occupationally ill/injured employees". OMFS will be utilized to calculate reimbursement.
- Section 9789.32: (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
- **§ 9789.15.4 Physical Medicine / Chiropractic / Acupuncture Multiple Procedure Payment Reduction; Pre-Authorization for Specified Procedure/Modality Services**
(1) The Medicare Multiple Procedure Payment Reduction ("MPPR") for "Always Therapy" Codes shall be applied when more than one of the following codes is billed on the same day: codes on the Medicare "Always Therapy" list, acupuncture codes, chiropractic manipulation codes. (2) Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. **The MPPR applies to the Practice Expense ("PE")** payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or

procedure with the highest PE payment. Full payment is made for the work and malpractice components and 50 percent payment is made for the PE for subsequent units and procedures, furnished to the same patient on the same day.

- Multiple Procedure (MPPR) Formula: $((\text{Work RVU} \times \text{Statewide Avg GAF}) + ((\text{Facility PE RVU} \times .5) \times (\text{Statewide PE GAF}) + (\text{MP RVU} \times \text{Statewide MP GAF})) \times (\text{Conversion Factor}))$
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 97140.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97140

Date of Service: 6/22, 6/25, 6/29 and 7/2 2015						
Physical Medicine						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
97140	\$463.00	\$37.48	\$425.52	1	\$25.90 x 4 Dates of Service = \$103.60	\$66.12 Due Provider Refer Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]