MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 9, 2016

[redacted]

IBR Case Number:	CB16-0000803	Date of Injury:	03/29/2010
Claim Number:	[redacted]	Application Received:	05/16/2016
Claims Administrator:	[redacted]		
Date(s) of service:	12/10/2015 – 02/01/2016		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	97110-GO/GP		

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 $98.92 in additional reimbursement for a total of $293.92. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$293.92** 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,

MAXIMUS

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
- 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 97110 Therapeutic procedure, 1 or more areas; therapeutic exercises to develop strength and endurance, range of motion and flexibility, billed as primary and secondary procedures on multiple dates of service.**
- The Claims Administrator's reimbursement rational indicates: "Contract Rate."
- Progress report and UB-04 reviewed; Manual Therapy and Therapeutic Exercise documented.
- Contractual Agreement not received for IBR and PPO discount cannot be extrapolated from submitted EOR's; OMFS will be utilized to calculate reimbursement.
- **CPT 97110 PC/TC indicator of "7."** Physical therapy service, for which payment may not be made--Payment may not be made if the service is provided to either a patient in a hospital outpatient department or to an inpatient of the hospital **by an independently practicing physical or occupational therapist.**
    - **UB-04 Does not Indicate Physical Therapist in Private Practice**
    - **Visit Documentation reflects one Physical Therapist for each date of service with no indication the Physical Therapist of Record is in Private Practice.**

- **CCR § 9789.32 (c)** The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for services in (a) will be determined as follows:

- (1)(A) For services rendered before September 1, 2014, the maximum allowable hospital outpatient facility fees for **professional medical services which are performed by physicians and other licensed health care providers to hospital outpatients** shall be paid according to Section 9789.10 and Section 9789.11.

- **(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.

  - (i) If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.

  - (ii) For Other Services, which do not meet the requirement in (i), the hospital outpatient facility fee shall be determined based solely on the non-facility practice expense relative value units applicable under the OMFS RBRVS.

  - **(iii) The fees for any physician and *non-physician practitioner professional services billed by the hospital shall* be calculated in accordance with the OMFS RBRVS, using the OMFS RBRVS total facility relative value units.**

- EOR reimbursement indicates probable reimbursement under "ii" of CCR § 9789.32 (c)(B). However, since the services were ***billed by the hospital*** for ***non-physician*** *practitioner professional services* and there is *no indication that the Physical Therapist was* ***in Private Practice*** at the time of the visits, it is reasoned that ***CCR § 9789.32 (c)(B)(iii)*** best describes the applicable reimbursement rational.
- **§ 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.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 97110 –GP x multiple units for multiple dates of service.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97110-GO/GP

Date of Service: 12/10/2015 – 02/01/2016 Physical Medicine						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
97110	$225.00	$533.66	$98.92	17	$632.58	**$98.92 Due Provider**

Copy to:

[redacted]

[redacted]