

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 17, 2015

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

IBR Case Number:	CB14-0001693	Date of Injury:	08/17/2011
Claim Number:	[REDACTED]	Application Received:	11/11/2014
Claims Administrator:	[REDACTED]	Assignment Date:	07/28/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97113-59 & 97002-59		

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 and 97002 PT Re-Evaluation Services Performed 09/26/2014.
- 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, date of service 09/26/2014 reflect the following submitted codes: 970002, 97113, & 97150.
- 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 of Patient visit includes Aquatic documentation noting supervision by Therapist.
- Documentation regarding start and end times for the Aquatic (97113) session versus Group (97150) sessions is not clearly defined. Specifically, the “start” and “end” times of each activity is not documented.
- **General Information and Instructions (8 CCR § 9789.11 1(f) Physical Medicine 97002 PT Re-Evaluation.** Follow-up evaluations for routine reassessments are included in the value of the initial assessment unless the patient’s condition requires one or more of the following: 1) a significant change in treatment plan, 2) to report permanent and stationary status 3) services over and above the normal therapeutic service. 3) to meet

reporting requirements as dictated in Title 8, California Code of Regulations Section 9785 (f)

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97113 -59 & 97002-59

Date of Service: 09/26/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
97113	\$138.46	\$0.00	\$138.46	N/A	1	\$0.00	Refer to Analysis
97002	\$65.97	\$0.00	\$65.97	N/A	1	\$0.00	Refer to Analysis
97150	N/A	N/A	N/A	N/A	N/A	N/A	Not in Dispute

Copy to:

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[REDACTED]
[REDACTED]

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