

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 4, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001816	Date of Injury:	01/22/2014
Claim Number:	[Redacted]	Application Received:	10/03/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	06/02/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	98940		

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 \$32.86 in additional reimbursement for a total of \$227.86. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$227.86 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: 5% PPO Discount
- 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 seeking remuneration for CPT 98940, Chiropractic manipulative treatment (CMT); spinal, 1-2 regions.
- Claims Administrator denied code indicating on the Explanation of Review “The procedure, material or service is not normally charges” and “According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due”
- Treatment Note submitted documents procedure on date of service 6/2/2015 as “The patient received chiropractic manipulation to lumbar spine, thoracic spine”
- Letter dated May 13, 2015 shows Utilization Review Determination & Authorization for Chirophysiotherapy 2x3 for Lumbar Spine, Begin Date: 05/13/2015 and Expiration Date: 08/11/2015. Letter documents “The treatment noted above has been determined to be medically necessary for the following reasons...”
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed

pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.

- Authorization dated May 13, 2015 is contract in nature. Therefore, reimbursement of 98940 is warranted.
- EOR received reflects a 5% PPO discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 98940

Date of Service: 06/02/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
98940	\$69.18	\$0.00	\$34.59	1	\$32.86	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]