

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 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001843	Date of Injury:	08/04/2014
Claim Number:	[Redacted]	Application Received:	10/06/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	97813, 97814, 97110		

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 \$142.87 in additional reimbursement for a total of \$337.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$337.87 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: N/A
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 codes 97813, 97814 and 97110 on date of service 3/19/2015

- Claims Administrator denied codes with rationale “
- 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. The MPPR applies to acupuncture codes and chiropractic manipulation codes and to the procedures listed in the “Separately Payable Always Therapy Services Subject to the Multiple Procedure Payment Reduction (MPPR)” file of the Medicare Physician Fee Schedule Final Rule. The listed procedures will also have a Multiple Procedure value of “5” on the National Physician Fee Schedule Relative Value File. **When billing for physical medicine modality, procedure, or acupuncture codes, no more than 60 minutes on the same visit.**
- CMS 1500 documents:

1. 1 unit of 97813, Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
 2. 2 units of 97814, Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
 3. 1 unit of 97110, Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
- Total time for acupuncture on date of service 3/19/2015 is 60 minutes.
 - Provider's Treatment Sheet documents 15 minutes of 97813, 30 minutes of 97814 and 15 minutes of 97110 and is signed by the injured worker.
 - Based on aforementioned and guidelines, reimbursement of 97813, 97814 and 97110 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 97813, 97814 and 97110.

Date of Service: 03/19/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
97813	\$95.00	\$0.00	\$	1	100%	\$47.68	\$47.68 Due to Provider
97814	\$100.00	\$0.00	\$	2	100%	\$75.14	\$75.14 Due to Provider
97110	\$45.00	\$0.00	\$	1	50%	\$20.05	\$20.05 Due to Provider

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