MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

Amendment

12/14/2015 Decision Amended

12/22/2015

[redacted]

IBR Case Number:	CB15-0002130	Date of Injury:	04/17/2013
Claim Number:	[redacted]	Application Received:	11/20/2015
Assignment Date:	12/10/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	07/09/2015 – 07/09/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	97110, 97035, 97010, and 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 $25.85 in additional reimbursement for a total of $220.85. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$220.85** 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]

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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 flexibility97140 Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, 97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes and 97010 Application of a modality to 1 or more areas; hot or cold packs for date of service 07/09/2015.**
- The Claims Administrator's reimbursement rational reflects a multiple procedure reduction.
- Opportunity to Dispute communicated to Claims Administrator on 11/24/2015; response not yet received.
- Contractual Agreement not received for IBR; OMFS will be utilized.
- UB04, bill type 133.
- RFA not submitted for review.
- Authorization dated 5/29/2015 indicates "Certified" physical therapy "2x6" for the right shoulder. Specific CPT/HCPCS codes were not documented. Authorized service dates 05/29/2015 – 07/17/2015."
- Progress report and UB-04 reviewed; Manual Therapy and Therapeutic Exercise documented.
- Submitted services not in dispute; MPPR rational is issue in dispute.
- Date of Service 07/09/2015 indicates the following Physical Medicine services were provided:
  - 97110

    - 97140
    - 97035
    - 97010
    - No other Physical Medicine procedures reflected.
- **CPT 97010 Title 8 CCR § 9789.11(a)(l) General Instructions**: The application of hot or cold packs is not reimbursable (i.e., code 97010 has a relative value of 0. 0 and is not reimbursable).
- **CPT 97110, 97140 and 97035 are reimbursable under the Physician's Fee schedule** and subject to MPPR.
- **Based on aforementioned documentation and guidelines, reimbursement is indicated for Primary Procedure 97110, Secondary Procedure 97140 and Tertiary Procedure 97035; reimbursement is not indicated for 97010.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97110, 97035, 97010, and 97140

Date of Service: 07/09/2015					
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Workers' Comp Allowed Amt.**	**Notes**
97110	$140.00	$20.60	$40.10	$40.10	(-) Overpayment for 97035 = $16.86 Due Provider
97035	$110.00	$6.56	$12.39	$3.92	$2.64 Over Payment
97140	$110.00	$18.73	$27.72	$27.72	$8.99 Due Provider
97010	$60.00	$0.00	$7.50	$0.00	Refer to Analysis

Copy to:

[redacted]

Copy to:

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