

**MAXIMUS FEDERAL SERVICES, INC.**

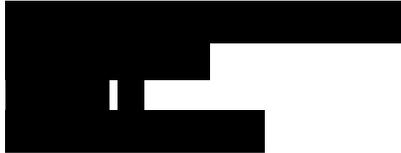
Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 25, 2016



IBR Case Number:	CB16-000019	Date of Injury:	07/11/2014
Claim Number:	[REDACTED]	Application Received:	01/05/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/24/2015 – 08/24/2105		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97002		

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 \$25.79 in additional reimbursement for a total of \$220.79. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$220.79** 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

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cc:



## 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)
- Other: OMFS Outpatient Hospital 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 additional reimbursement for CPT 97002 (Date of service 8/24/2015).**
- Provider billed the physical therapy procedure code as part of hospital service on a UB04 with bill type 131.
- Pursuant to 9789.32(c)(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.
- Provider is seeking reimbursement up to the OMFS allowance, as stated on IBR application “Expected payment at RBRVS” and PPO contract is “100% of Fee Schedule.”
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 1/06/2016; response not yet received.
- Reimbursement from the Claims Administrator was less than RBRVS allowance for the billed units for CPT 97002.
- The following regulations & guidelines apply to the billed therapy codes:
  - (a) (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.
- Additional reimbursement is warranted for CPT 97002, based on RBRVS allowances based on date of service.

**DETERMINATION OF ISSUE IN DISPUTE: 97002.**

Date of Service 8/24/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Date of Service / Units billed	Workers’ Comp Allowed Amt.	Notes
97002	\$	\$26.22	\$25.79	8/24/2015	\$52.01	<b>Refer to Analysis: 100% for first unit. Additional 25.79 due to the provider.</b>

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