MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Reversed

4/10/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 7/16/2013 – 7/16/2013
MAXIMUS IBR Case: CB13-0000835

Dear [redacted]

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/27/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of $335.00 and the amount found owing of $1,966.49, for a total of $2,301.49.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:
The following evidence was used to support the decision:

- 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 or negotiated contract: PPO Contract
- Other: Official Medical Fee Schedule Guidelines

Supporting Analysis:
The dispute regards payment amount for functional restoration program services performed on date of service 7/16/2013. The Provider billed CPT 97799 Modifier 86, was reimbursed $533.51, and is requesting additional reimbursement of $1,966.49. The Claims Administrator reimbursed the Provider $533.51 with the explanation "The value of the service performed is established by identifying each individual service." The Claims Administrator's explanation of review did not provide an explanation on how the reimbursement was determined or the procedure codes the reimbursement was based on.

CPT 97799 - Unlisted physical medicine service or procedure
Modifier 86 - This modifier is to be used when prior authorization was received for services that exceed the OMFS ground rules.

The Provider submitted Functional Restoration Program Psychological, Behavioral and Musculoskeletal Evaluation reports. Per the Provider, the program evaluation involves a series of medical professionals of different specialties. The medical reports submitted documented evaluations by the following: Medical Doctor, Psychologist, and Physical Therapist. The medical record documented an Evaluation and Management services (History, Musculoskeletal Examination and Medical Decision Making) and Diagnostic Psychological Testing (Symptom List 90 Revised, Millon Behavioral Medicine Diagnostic and Pain Patient Profile). The medical record submitted included a "Program Initial Evaluation and Multidisciplinary Conference" report. The services were billed as procedure code 97799 Modifier 86 with a billed amount of $2,500.00 The request for treatment authorization from the Provider indicated a request for "Initial Evaluation at the Functional Restoration Program (97799 X 1)" and cost of $2,500.00 was documented. The request indicated the Provider's usual and customary charges of $2,500.00 for the Functional Restoration Program Initial Evaluation services. The authorization from the Claims Administrator did not indicate a pre-negotiated allowance of $533.51 or the reimbursement for the functional restoration program evaluation services would be based on a specific procedure code(s).

The documentation included a copy of the PPO contract. Per the PPO Contract, Covered services rendered by Preferred Providers are to be reimbursed at the lesser of 100% of billed charges or the following fee schedule: Worker's Compensation. The Worker's Compensation reimbursement is "Lesser of the physician's/practitioner's usual and customary fees or 95% of the reasonable maximum fee established by California Workers' Compensation Regulations, using the procedure numbers, unit values, and conversion factors adopted by the California Department of Industrial Relations." There is no allowance listed under the OMFS for the billed procedure code 97799 Modifier 86. The Provider documented their usual and customary charge of $2,500.00 in the treatment authorization request. The billed services should have been reimbursed based on the Provider's usual and customary billed charges.

The additional reimbursement of $1,966.49 is warranted per the Official Medical Fee Schedule code 97799 Modifier 86.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
97799	86	1	$1,966.49	$2,500.00	$533.51	$1,966.49	PPO Contract

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**$335.00**) and the OMFS amount for CPT code 97799 Modifier 86 ($1,966.49) for a total of $2,301.49.

The Claims Administrator *is required to reimburse the provider $2,301.49 within* ***45 days of date on this notice per section 4603.2 (2a).*** *This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(*f).

Sincerely,

[redacted], RHIT

Copy to:
[redacted]

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