

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 21, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001650	Date of Injury:	05/12/1998
Claim Number:	[REDACTED]	Application Received:	07/29//2014
Claims Administrator:	[REDACTED]	Assignment Date:	12/04/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99499		

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 \$250.00 for the review cost and \$0.00 in additional reimbursement for a total of \$250.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$250.00 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,

[REDACTED]
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

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 full remuneration for 99499 Unlisted Evaluation and Management services representing Functional Restoration Program for service dates 04/07/2014 – 04/11/2014.**
- **1st EOR** dated 04/22/2014 indicating \$1,072.62 reimbursed to Provider with the following rational: “No reimbursement was made for the E/M service as the documentation does not support a separate significant identifiable E&M service performed with other services provided on the same day.”
- **2nd Bill Review** request and letter from Provider addressed to Claims Administrator dated 05/20/2014.
- Outcome of 2nd Bill Review not available for IBR.
- FRP services not in dispute.
- Full reimbursement for FRP services is in dispute.
- 99499 utilized by Provider for Functional Restoration Program as a CPT code for FRP does not exist. As such, a “Comparable Code” or reimbursement at the Providers “Usual and Customary” charge may be reimbursed if the services were authorized.
- FRP services were authorized as indicated on Authorization from Claims Administrator dated “March 14, 2014.”

- Reimbursement of \$1,072.62 on 04/22/2014 from the Claims Administrator indicates 99499 as accepted as FRP service code.
- IBR Case Received 07/29/2014. Letter from Claims Administrator dated 11/06/2014 indicates Claims Administrator released additional funds to Provider on October 9, 2014 with reimbursement based on the following codes:
 - 97001 Physical Therapy
 - 99214 Evaluation and Management
 - 90791 Psychiatric Diagnostic Evaluation
 - 97750 Physical Performance Test x 4 hours
- Above codes were reimbursed x 5; representing 04/07/2014 – 04/11/2015 – 15% PPO Reduction = \$4,223.30
- OMFS allows for Unlisted Procedure Codes to be reimbursed by “By Report.”
- §9789.12.4 (c) “In determining the value of a By Report procedure, consideration may be given to the value assigned to a **comparable** procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed.”
- Assigned codes by the Claims Administrator appear to be within the same scope of practice/time/complexity/expertise/& expense when compared to the six (6) page Functional Restoration Program Report submitted for IBR.
- Contractual Agreement not available for IBR, Claims Administrator indicates in the above referenced letter a “15%” reduction from OMFS.
- Reimbursement of assigned codes were reimbursed according to the OMFS and 15% reduction
- Based on the aforementioned documentation and guidelines, additional reimbursement above \$4,223.30 is not indicated. However, the Provider is due \$250.00 filing fee as additional reimbursement to Provider on 10/09/2014 submitted after IBR filing of 07/29/14.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 97899-86.

Date of Service 04/07/2014 – 04/11/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99499	\$5,605.00	\$4,223.30	\$1,381.70	N/A	1	\$4,223.30	Refer to Analysis
97001	N/A	N/A	N/A	N/A	N/A	N/A	Code Not In Dispute
99214	N/A	N/A	N/A	N/A	N/A	N/A	Code Not In Dispute
90791	N/A	N/A	N/A	N/A	N/A	N/A	Code Not In Dispute
97750	N/A	N/A	N/A	N/A	N/A	N/A	Code Not In Dispute

Copy to:

[REDACTED]
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