

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 30, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001871	Date of Injury:	02/07/2013
Claim Number:	[REDACTED]	Application Received:	12/05/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	2/4/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97750		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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: PPO Contract

## 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 is dissatisfied with reimbursement of code 97750
- Claims administrator reimbursed \$956.41 indicating on the Explanation of Review “Pricing reductions due to MPN”
- Provider states “The adjuster agreed to the rate on our RFA per email dated 9-19-14. Rate is \$3,000.00 for 8 hrs/\$93.75 per unit”
- Claims administrator submitted a documented dispute stating “There is a contractual issue – the discount taken was due to PPO contract.”
- Provider’s Request for Authorization included “Service/Good Requested: Functional Capacity Evaluation with provider; CPT/HCPCS Code: 97670; Frequency, Duration Quantity, etc: 8 hours = \$3,000”. Claims administrator’s email dated July 10, 2014 states “I approved for whatever was ordered by the doctor on the RFA.”
- Provider billed CPT code 97750 on a CMS 1500 form. Provider also documents on the IBR application under Please select all applicable Fee Schedules: Contract Reimbursement Rates.
- Claims administrator states “If the dispute centers on the applicability of the contract in place, it must be rejected, as rule §9792.5.7(b) requires this to be resolved first before proceeding to IBR”
- The dispute appears to be a contract issue which is not to be determined by the reviewer.
- Based on information reviewed, additional reimbursement for code 97750 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 97750 is not recommended.

<b>Date of Service:</b> 8/15/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
97750	\$1687.50	\$956.41	\$731.09	18	N/A	\$956.41	<b>DISPUTED SERVICE:</b> No further reimbursement is recommended.

Copy to:

[REDACTED]

Copy to:

[REDACTED]