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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 6, 2015

[redacted]

IBR Case Number:	CB15-0000044	Date of Injury:	05/01/1999
Claim Number:	[redacted]	Application Received:	01/13/2015
Claims Administrator:	[redacted]		
Assigned Date:	2/3/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	97799-86		

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 $1084.85 in additional reimbursement for a total of $1280.84. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1280.84 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,

Chief Coding Reviewer

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
- Negotiated contracted rates: PPO Discount 8%
- National Correct Coding Initiatives

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 97799-86
- Provider's Request for Authorization stated "I am requesting authorization for an additional 10 days/50 hours (days 17-26) of FRP (5 hours per day) at this time in order to avoid a break in care". Provider documents $100 per day ($5000 per week) using code 99499 – Unlisted Evaluation & Management Service.
- Utilization Review approved appeal dated June 30, 2014 for an additional 50 hours of FRP. Claims administrator did not indicate the authorization procedure code 99499 would be down coded or any pre-negotiated rate. EOR states "The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service." Claims administrator based their payment on code 97750.
- Provider submitted a Reconsideration Request: Corrected Claim using code 9779-86 as they state "to better reflect services rendered in the Functional Restoration Program (FRP)"
- Claims administrator submitted additional payment to the provider after the Corrected Claim was processed using CPT code 97799-86.
- Provider's report submitted documents the injured worker's physical and mental status along with pain management, long term goals, medical treatment plan, motivation to change, adaptive responses to pain/injury and interventions.
- The allowance is to be calculated based on the PPO contract and an 8% discount is to be applied to reimbursement.

- The provider documented the Usual & Customary fees on the request for treatment authorization
- Based on information reviewed, additional reimbursement for code 97799-86 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 97799-86 is recommended.

Date of Service: 6/30/2014 – 7/03/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
97799-86	$4000.00	$2594.16	$1405.84	5 Days	N/A	$3680.00	**DISPUTED SERVICE**: Allow reimbursement $1085.84

Copy to:

[redacted]

Copy to:

[redacted]