MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 1, 2015

[redacted]

IBR Case Number:	CB15-0000208	**Date of Injury:**	03/29/2012
Claim Number:	[redacted]	**Application Received:**	02/17/2015
Claims Administrator:	[redacted]	**Assignment Date:**	03/05/2015
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: 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, M.D., M.P.H.
Medical Director

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
- Partial (1 page) Contractual Agreement

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 Initial Functional Restoration Evaluation services, billed as Unlisted Procedure Code 97799 -86, for date of service 07/31/2014.**
- The Claims Administrator reimbursed the Provider $2,125.00 of $2,500.00 with the following rational: "Multiple Procedure Payment Reduction Rule Applied per CA DWC regs effective 01/01/2014."
- Modifier -86: OMFS "This Modifier is used when prior authorization was received for services that exceed OMFS ground rules."
- 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."
- There is no allowance listed under the OMFS for the billed procedure code 97799 or, more specifically, an Initial Functional Restoration Program Evaluation, and a comparable procedure code does not exist.
- CPT 97799 By Report Code is not subject to MPPR as there is no unit value or conversion factor associated with this By Report Code.

- The Provider's Usual and Customary Fee is presented on the Authorization Request dated 01/31/2014 as "$2,500.00."
- Authorization for Initial FRP dated 07/13/2014 signed by Claims Administrator does not indicate a procedure coded and does not indicate agreement of charges. As such, the OMFS or contractual agreement dictates reimbursement.
- Functional Restoration Program service is authorized meeting the criteria for Modifier -86.
- Recommend reimbursement for 1 unit of 97799-86 representing dates of service 07/31/2014.
- **California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11**: 5307.11. A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code **shall not apply to the contracted reimbursement rates.** Except as provided in subdivision (b) of Section 5307.1, the official medical fee schedule shall establish maximum reimbursement rates for all medical services for injuries subject to this division provided by a health care provider or health care facility licensed pursuant to Section 1250 of the Health and Safety Code other than those specified in contracts subject to this section.
- Partial one page Contractual Agreement provided for IBR, entitled "Fee for Service Rates," for "Unlisted Procedures," reflect "**60% of Providers Usual and Customary Fee.** The 95% indicated on the contract refers to deductions taken from "unit value" and "conversion factors" for **established** CPT Codes.
- CPT 97799 is a By Report Code without a comparable procedure, without a 'unit value' or conversation factor. As such, the contractual reimbursement rate defaults to the 'Unlisted Procedure,' reimbursement contract terms as per **LC §5307.11 – "the medical fee schedule shall not apply to the contracted reimbursement rates."**
- Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for Unlisted Procedure Code 97799-86.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is not warranted for 97799-86

Date of Service: 07/31/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
97799 - 86	$2,500.00	$2,125.00	$375.00	N/A	1	$2,125.00	Refer to Analysis

Copy to:

[redacted]

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