

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 31, 2015

██████████  
██████████  
████████████████████

IBR Case Number:	CB15-0001261	Date of Injury:	08/02/2012
Claim Number:	██████████	Application Received:	08/03/2015
Assignment Date:	08/20/2015		
Claims Administrator:	██████████		
Date(s) of service:	01/26/2015 – 01/30/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	97799-86		

Dear ██████████

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 \$4,916.25 in additional reimbursement for a total of \$5,111.25. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$5,111.25** 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,

Paul Manchester, M.D., M.P.H.  
Medical Director

cc: ██████████  
████████████████████████████████████████

## 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 Contractual Agreement: 95%

## 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 Functional Restoration Initial Evaluation services, billed as Unlisted Procedure Code 97799-86, for date of service 01/26/2015 – 01/30/2015.**
- Claims Administrator denied FRP services stating, “The billing has exceeded the fee schedule guidelines for payment of physical therapy or physical medicine treatment.”
- Functional Restoration Program service not in dispute.
- Total Payment for FRP is in dispute.
- Request for FRP states the Providers Usual and Customary fee of 160 hours @ \$225 an hour; faxed to Claims Administrator by Provider on 11/06/2014.
- Modifier -86: OMFS Modifier is used when prior authorization was received for services that exceed OMFS ground rules.
- Authorization for Functional Restoration Program presented for IBR, dated February 11, 2015 signed by Claims Administrator; criteria for Modifier -86 met.
- 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.”

- Partial contractual agreement submitted for IBR indicates “95%” of “Eligible Billed Charges” for procedure codes with “no assigned value.”
- Opportunity to Dispute Edibility sent to Claims Administrator on 08/04/2015; response not yet received.
- **LC § 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.
- There is no allowance listed under the OMFS for the billed procedure code 97799 or, more specifically, a Functional Restoration Program; a CPT Code has yet to be formulated for this comprehensive program involving multiple specialties. As such, the Physical Medicine Modality MPPR Reduction applied by the Claims Administrator is in correct; the contractual agreement will dictate the level of reimbursement pursuant to LC § 5307.11.
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 97799-86

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 97799 - 86**

<b>Date of Service:</b> 01/26/2015 – 01/30/2015.							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surge on</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
97799-86	\$6,075.00	\$855.00	\$4,916.25	N/A	1	\$5,771.25	PPO ( - ) Reimbursed Amount = \$4,916.25 Due Provider

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