

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 3, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001317	Date of Injury:	06/22/1998
Claim Number:	[Redacted]	Application Received:	08/10/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	04/02/2013		
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 \$356.25 in additional reimbursement for a total of \$551.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$551.25 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: [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
- Partial PPO 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 remuneration for Initial Evaluation Functional Restoration billed as Unlisted Procedure Code 97799-86.**
- Initial Evaluation Functional Restoration Program service not in dispute.
- Payment for Initial Evaluation FRP is in dispute.
- Request for Initial Evaluation FRP states the Providers Usual and Customary fee of \$2500.00 sent to Claims Administrator by Provider on 12/21/2012
- Authorization for Initial Evaluation FRP Certified by Claims Administrator on March 20, 2013. Fee reflected on original request is not stated on the Authorization.
- Modifier -86: OMFS Modifier is used when prior authorization was received for services that exceed OMFS ground rules.
- Authorization for Initial Evaluation Functional Restoration Program presented for IBR, dated 03/20/2013 signed by the Claims Administrator, indicates treatment is “medically necessary” meeting the 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.”

