

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 24, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000292	Date of Injury:	05/08/2012
Claim Number:	[Redacted]	Application Received:	3/3/2014
Claims Administrator:	[Redacted]		
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.

IBR Case Assigned: 4/17/2014

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 \$335.00 for the review cost and \$1140.00 in additional reimbursement for a total of \$1475.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1475.00 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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

[Redacted]
Chief Coding Reviewer

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 Discount
- National Correct Coding Initiatives
- Other: OMFS Physician Services Guidelines and Ground Rules

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 dissatisfied with reimbursement of code 97799-86

- Provider was reimbursed \$4560.00 and is seeking additional reimbursement of \$1440.00.
- The Explanation of Review received from the Claims Administrator reflects a zero reimbursement and indicates: “ Utilization review decision” and “Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or Provider” dated 07/03/2013.
- Explanation of Review received from the Provider shows Claims Administrator reimbursed the Provider \$4560.00 and indicated “The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance” dated 09/10/2013.
- PPO Contract reviewed shows a 5% discount is to be applied.
- Based on review of the Physician’s Weekly Progress Report, Physical Therapy Report, Psychological & Behavioral Progress Note, procedure code 97799-86 is substantiated as the Provider documented services performed.

- The Physician Evaluation details the injured worker’s medical history, current medications; physical examination including functional strength, range of motion, function movement and lifting, dynamic posture and stabilization, psychological evaluation, treatment plan and a formal request for authorization, a thorough evaluation was performed on this injured worker.
- Documents reviewed include the Request for Authorization of Medical Treatment for 97799-86 x 30 days at \$6000.00 a week.
- Claims Administrator’s Utilization Review was not received and cannot be used in this review. In the Provider’s Request for Independent Bill Review, it is stated: “First, these services were retro authorized by Zurich Claims Adjuster on 06/18/13, specifically for the Functional Restoration Program for weeks 3 & 4 (verbal cert #130305-269118-02) and all services were performed as authorized.”
- Claims Administrator is not refuting there was an authorization and did indeed pay the Provider based on Official Medical Fee Schedule. 97799 is an unlisted code and payment is based on the Provider’s Usual and Customary fee of \$6000.00 a week which is documented in his Request for Authorization for Medical Treatment.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, additional reimbursement of code 97799-86 is warranted in the amount listed below.

The table below describes the pertinent claim line information.

Date of Service: 06/10/2013 – 06/14/2013						
[REDACTED]						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
97799-86	\$ 6000.00	\$ 4560.00	\$ 1440.00	5 Days	\$ 5700.00	DISPUTED ISSUE: Allow reimbursement of \$ 1140.00

Copy to:

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[REDACTED]
[REDACTED]
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Copy to:

[REDACTED]
[REDACTED]
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