

**MAXIMUS FEDERAL SERVICES, INC.**

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

**Independent Bill Review Final Determination Reversed**

10/21/2014

██████████  
██████████  
██████████

IBR Case Number:	CB14-0000294	Date of Injury:	03/13/2007
Claim Number:	██████████	Application Received:	03/03/2014
Claims Administrator:	██████████		
Date(s) of service:	08/12/2013 – 08/16/2013		
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	97799-86		

Dear ██████████:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 04/18/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$5202.45 for a total of \$5537.45.**

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- 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 or negotiated contract: PPO Contract
- Other: OMFS Physician Services Guidelines and Ground Rules

**Analysis and Findings:**

- **ISSUE IN DISPUTE: Provider dissatisfied with reimbursement of code 97799-86.**
- Based on review of case documentation, the use of code 97799-86 is substantiated as the Provider documented services performed and Provider's Usual and Customary charge.
- The documentation submitted included the request for treatment authorization from the Provider. Provider was requesting 97799 x 30 days of NCFRP at \$6000.00 a week.
- Utilization Review dated 05/16/2013 included the request for 30 days of Functional Restoration Program but was certified for 10 days of Functional Restoration with an expiration of 08/30/2013. Claims Administrator did not indicate the authorization procedure code 97799 would be down coded, or a pre-negotiated rate of \$497.55.
- The report submitted documented the progress of the injured worker which included: range of motion; strength; functional improvements; independent self-management; psychological and behavioral progress notes.
- The allowance is to be calculated based on the PPO Contract and therefore the 5% discount is applicable for procedure codes for which there is no assigned value.
- The Provider documented the usual & customary fees on the request for treatment authorization.
- **DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of \$5502.45 is to be made to the Provider.**

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of service at issue.

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amount	Notes
<b><i>Date of Service – 08/12/2013 – 08/16/2013</i></b>						
<b><i>Functional Restoration Therapy</i></b>						
97799- 86	\$6000.00	\$497.55	\$5202.45	5 Days	\$5700.00	<b>DISPUTED SERVICE – Additional reimbursement to the provider to be made for \$5202.45</b>

**Determination: Reversed**

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee **(\$335.00)** and the OMFS amount for CPT code 97799-86 (\$5202.45) for a total of \$5537.45.

***The Claims Administrator is required to reimburse the provider \$5537.45 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).***

Sincerely,

██████████, RHIT  
Chief Coding Reviewer

Copy to:

██████████  
██████████  
██████████

Copy to:

Division of Workers' Compensation Medical Unit  
1515 Clay Street, 18th Floor  
Oakland, CA 94612