

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 4, 2014

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0000031	Date of Injury:	11/17/2011
Claim Number:	[Redacted]	Application Received:	01/09/2014
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: 09/29/2014

**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 \$2475.00 in additional reimbursement for a total of \$2810.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2810.00 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 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,

[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
- 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.**
- 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 5 Days of NCRFP at \$6000.00 a week.
- Utilization Review approved 5 days of Functional Restoration Program dated September 23, 2013. Functional Restoration Program certified period was between 09/23/2013 – 12/23/2013.
- Claims Administrator reimbursed a partial payment indicating on the Explanation of Review: "Paid at rate and rules of contract indicated."
- The Physician's Progress Report submitted documents the progress of the injured worker which included: range of motion; strength; lifting, posture and stabilization, functional improvements; independent/self-management; psychological and behavioral note. A Discharge Summary is also included releasing the patient from the program.
- The allowance is to be calculated based on the PPO Contract and therefore the 10% discount is applied.
- The Provider documented the usual & customary fees on the request for treatment authorization.

**DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, additional reimbursement for CPT code 97799-86 is recommended.**

The table below describes the pertinent claim line information.

<b>Date of Service: 9/16/2013 – 9/20/2013</b>						
<b>Functional Restoration Therapy</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
<b>97799-86</b>	<b>\$6000.00</b>	<b>\$2925.00</b>	<b>\$2475.00</b>	<b>5 Days</b>	<b>\$5400.00</b>	<b>DISPUTED SERVICE: Allow Additional Reimbursement \$2475.00</b>

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