

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 29, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001336	Date of Injury:	03/29/2002
Claim Number:	[REDACTED]	Application Received:	09/15/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/13/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97799		

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 \$250.00 for the review cost and \$375.00 in additional reimbursement for a total of \$625.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$625.00 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]
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
- Official Medical Fee Schedule
- Partial Contractual Agreement

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 02/11/2014.**
- Claims Administrator denied FRP services stating, “Adjusted to usual and customary fee for this type of service.”
- PPO Contractual Agreement section for procedure codes with no assigned value reflects “95% of Eligible Charges.”
- Functional Restoration Program service not in dispute.
- Payment for Initial FRP is in dispute.
- Request for FRP Initial Evaluation states the Providers Usual and Customary fee of \$2,500.00; faxed to Claims Administrator by Provider on 01/14/2014.
- Authorization for FRP Initial Evaluation signed by Claims Administrator on January 21, 2014. Fee reflected on original request is not stated on the Authorization.
- The documentation included a partial copy of the PPO contract. Per the PPO Contract, “For Covered Services billed with a procedure code for which there is no assigned value in Sections 4A and 4B above, Provider shall be reimbursed at 95% of Eligible Billed Charges.”

- There is no allowance listed under the OMFS for the billed procedure code 97799 Modifier 86. The Provider documented their usual and customary charge of \$2,500.00 in the treatment authorization request. The billed services should have been reimbursed based on the Provider’s usual and customary billed charges, with a deduction of 95% as stated in the contractual agreement.
- 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: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for

Date of Service: 06/16/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surge on	Units	Workers’ Comp Allowed Amt.	Notes
97799-86	\$2,500.00	\$2,000.00	\$500.00	N/A	1	\$2,375.00	PPO Contract – Reimbursed Amount = \$375.00 Due Provider

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