

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 31, 2014

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

IBR Case Number:	CB14-0001467	Date of Injury:	09/28/2009
Claim Number:	[REDACTED]	Application Received:	09/29/2014
Claims Administrator:	[REDACTED]	Assignment Date:	10/29/2014
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 \$250.00 for the review cost and \$1,741.88 in additional reimbursement for a total of \$1,991.88. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,991.88 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 06/13/2013.**
- Claims Administrator denied FRP services stating, “fee was reviewed to a standard of reasonableness based on comparisons to industry benchmarks of charges and reimbursement for comparable services in your area.”
- Contractual Agreement reimbursement based on “reasonableness” not available for IBR.
- PPO Contractual Agreement section for “unassigned value,” reflects “95% of Eligible Charges.”
- Functional Restoration Program service not in dispute.
- Payment for FRP is in dispute.
- Request for FRP states the Providers Usual and Customary fee of \$2,500.00; faxed to Claims Administrator by Provider on 5/1/2013.
- Authorization for FRP signed by Claims Administrator on 5/15/2013. Fee reflected on original request is not stated on the Authorization.
- The documentation included a copy of the PPO contract. Per the PPO Contract, Covered services rendered by Preferred Providers are to be reimbursed at the lesser of 100% of billed charges or the following fee schedule: Worker's Compensation. The Worker's

Compensation reimbursement is "Lesser of the physician's/practitioner's usual and customary fees or 95% of the reasonable maximum fee established by California Workers' Compensation Regulations, using the procedure numbers, unit values, and conversion factors adopted by the California Department of Industrial Relations." 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: 06/13/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
97799-86	\$2,500.00	\$633.12	\$1866.88	N/A	1	\$2,375.00	PPO Contract – Reimbursed Amount = \$1,741.88 Due Provider

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