

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 7, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000414	Date of Injury:	01/12/2011
Claim Number:	[Redacted]	Application Received:	03/17/2014
Claims Administrator:	[Redacted]	Assignment Date:	05/19/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	97670		

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 \$335.00 for the review cost and \$726.80 in additional reimbursement for a total of \$1061.80. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1061.80 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: None
- National Correct Coding Initiatives
- Other: OMFS Physicians Fee Schedule

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 is dissatisfied with reimbursement of CPT code 97670.
- Claims Administrator reimbursed Provider \$427.34 indicating on the Explanation of Review “Exceeds time limitation guideline” and “Functional Capacity Eval allowance.”
- Authorization received shows approval for 1 unit Physical Performance Test for tear med cart/meniscus knee. No mention of negotiated amount or fee was found as CPT 97670 is an unlisted By Report. Therefore, no additional reimbursement for CPT 97670 is recommended.
- Functional Capacity Evaluation Report submitted documents history of injury, physical examination, functional measures including step test, sit to stand, lifting and strength tests. Page 8 of this report, the Provider documents 2 hours examining the patient and analyzing self-report measures, 5 hours of medical literature research was incorporated in preparation of this examine...” Provider did not submit any documentation of negotiated fee or fee charges for Functional Capacity Evaluation. However, Provider does state “5 hours of medical literature research” and therefore, a Prolonged service code may be utilized.
- CPT 99358: Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records, job analysis, evaluation of ergonomic status, work limitations, work capacity, or communication with professionals and/or the patient/family): each 15 min.

