

**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**

10/3/2014

██████████  
██████████  
██████████

IBR Case Number:	CB14-0000686	Date of Injury:	06/05/2012
Claim Number:	██████████	Application Received:	05/05/2014
Claims Administrator:	██		
Date(s) of service:	02/17/2014 – 02/21/2014		
Provider Name:	████████████████████████████████████		
Employee Name:	██████████████████████████████████		
Disputed Codes:	97799-86		

Dear ██████████

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 06/27/2014, 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 \$250.00 and the amount found owing of \$1,128.00 for a total of \$1378.00.**

**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 an authorization for Functional Restoration Program for 10 days Functional Restoration Program starting 02/17/2014.
- Notice of Utilization Review Decision included the request for 30 days Functional Restoration Program but granted 10 days of Functional Restoration Program, Treatment to begin 07/17/2013 and to end 08/31/2013, based on CA Medical Treatment Utilization Schedule (MTUS) 2009, Chronic Pain Treatment Guidelines page 49.
- The submitted report documented the progress of the injured worker which included: range of motion; strength; functional improvement; independent self-management; psychological and behavioral progress note. The request for treatment authorization from the Provider, requested 97799 x 30 days of NCRFP at \$6,000.00 per week.
- Explanation of Review states: Reimbursement for physical medicine procedures, modalities, including Chiropractic Manipulation and acupuncture codes are limited to 60 minutes per visit without prior authorization pursuant to Physical Medicine rule 1. Authorization had been granted on July 17, 2013 prior to date of service 02/17/2014.
- The allowance is to be calculated based on the PPO Contract and therefore the 6% 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 \$1,128.00 to be made to the provider.**

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amount	Notes
<i>Date of Service – 02/17/2014-02/21/2014</i> <i>Functional Restoration Therapy</i>						
97799- 86	\$6,000.00	\$4,512.00	\$1,128.00	30 hours	\$5,640.00	<b>DISPUTED SERVICE – Additional reimbursement to the provider to be made for \$1,128.00.</b>

**Determination: Reverse**

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 (**\$250.00**) and the OMFS amount for CPT code 97799 Modifier 86 (\$1,128.00) for a total of \$1,378.00.

*The Claims Administrator is required to reimburse the provider \$1,378.00 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,

[REDACTED], RHIT  
Chief Coding Reviewer

Copy to:

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

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]