

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 12, 2015

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

| | | | |
|------------------------------|--------------|------------------------------|------------|
| IBR Case Number: | CB14-0001570 | Date of Injury: | 12/13/2012 |
| Claim Number: | [REDACTED] | Application Received: | 10/20/2014 |
| Claims Administrator: | [REDACTED] | Assignment Date: | 11/18/2014 |
| 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 \$3,633.75 in additional reimbursement for a total of \$3,883.75. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3,888.75 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, for date of service 05/05/2014-05/09/2014.**
- Claims Administrator denied FRP services stating, “Prior Authorization for services that exceed OMFS.”
- PPO Contractual Agreement section for procedure codes with no assigned value reflects “95% of Eligible Charges.”
- Functional Restoration Program service not in dispute.
- Payment amount for FRP services performed during 05/05/2014 – 05/09/2014 time period is in dispute.
- Documentation reveals a request for 80 additional hours of FRP requested by Provider on 4/18/2014.
- Authorization for 80 additional hours of FRP services approved by Claims Administrator on 4/25/2014 indicating “Authorization Timeframe” as 04/21/2014 – 06/21/2014.
- FRP services performed 05/05/2014 – 05/09/2014 and is within the authorized time frame indicated.
- 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.
- Authorization does not indicate a capitation amount for FRP or Unlisted services.
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 97799.

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 97799

| Date of Service: 05/05/2014 -05/09/2014 | | | | | | | |
|---|-----------------|--------------|----------------|-----------------|-------|----------------------------|--|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surge on | Units | Workers' Comp Allowed Amt. | Notes |
| 97799 | \$4,725.00 | \$855.00 | \$3,633.75 | N/A | 1 | \$4,488.75 | PPO Contract – Reimbursed Amount = \$3,633.75 Due Provider |

Copy to:

[Redacted]

Copy to:

[Redacted]