

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 15, 2015

[Redacted]

<b>IBR Case Number:</b>	CB14-0001621	<b>Date of Injury:</b>	04/03/2009
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/27/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	12/10/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	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 \$973.84 in additional reimbursement for a total of \$1,223.84. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1,223.84 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]

cc: [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: 95% OMFS

## 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 07/14/2014-07/18/2014.**
- Claims Administrator denied FRP services stating, “Prior authorization received for services that exceed the OMFS ground rules, “ and “Charges were reduced to 80% of fee schedule value as services were rendered by a CRNA Labor Code 5307.1”
- PPO Contractual Agreement section for “unassigned value,” reflects “94% 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 \$225.00 hour for 160 hours of FRP; faxed to Claims Administrator by Provider on 5/29/2014, for dates of service 7/14/2014-07/18/2014.
- Authorization received by the Claims Administrator on 05/12/2014
- Authorization approved for “80 hours” by Claims Administrator on 05/14/2014. Fee reflected on original request is not stated on the Authorization. However, an exclaimer does exist on authorization as follows: “certification of the treatment referenced below is not an approval of benefits. Only a claim adjuster may make guarantee of payment. All

treatment is subject to the policy provisions as well as state regulations regarding edibility and compensability.”

- 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 \$250.00 hour for 160 hours in the treatment authorization request.
- The Claims Administrator based reimbursement on less “80%” as per Labor Code 53071.
- Although a Physical Therapist did perform a portion of the program, the “80%” deduction should not have applied to the entire program as the documentation indicates the physical therapist was the only non-physician/medical examiner recognized by the DWC.
- Abstracted Physical therapy note indicates the following: CPT 97002, Physical therapy re-evaluation; CPT 95834, Muscle testing, manual (separate procedure) with report - total evaluation of body, including hands; CPT 97110, Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
- OMFS 97002 = \$49.62; 95834 = 60.75; 97110 = \$37.79 = \$190.16 in Physical Therapy charges.
- $\$190.16 - \$6,075.00 = \$5,884.84$
- The ‘80%’ deduction does not apply to individual Physical Therapy Codes listed in the OMFS.
- 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 97899-86**

Date of Service: 07/21/2014 - 07/25/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
97799-86	\$6,075.00	\$4,617.00	\$1,761.75	N/A	1	\$5,884.84	PPO Contract – Reimbursed Amount = \$1,267.84 Due Provider
97002	N/A	N/A	N/A	N/A	1	N/A	Refer to Analysis – Code Not In Dispute
95834	N/A	N/A	N/A	N/A	1	N/A	Refer to Analysis – Code Not In Dispute
97110	N/A	N/A	N/A	N/A	1	N/A	Refer to Analysis – Code Not In Dispute

Copy to:

██████████  
 ████████████████████  
 ████████████████████████████████

Copy to:

██  
 ██  
 ██