

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 2, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001768	Date of Injury:	01/17/2007
Claim Number:	[REDACTED]	Application Received:	11/19/2014
Claims Administrator:	[REDACTED]		
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.

IBR Case Assigned 12/23/2014:

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 \$272.99 in additional reimbursement for a total of \$522.99. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$522.99 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,

Paul Manchester, M.D.
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
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule & PPO Contract

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 dissatisfied with reimbursement of code 97799-86.
- Provider was reimbursed \$2,102.01 and is seeking additional reimbursement of \$272.99.
- Claims Administrator sent a partial payment in the amount of \$2,102.01 indicating on the Explanation of Review: “Charges reduced in accordance with base allowances per the applicable fee schedule.”
- CPT 97799; has a status code “C” and no listed RBRVUs.
- CCR 9789.12.4 “By Report” - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs
 - (a) An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report (report not separately reimbursable), justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.
 - (b) (1) In accordance with section 9789.12.3, when procedures with status indicator codes C, N, or R, do not have RVUs assigned under the CMS’ National Physician Fee Schedule Relative Value File, these services shall be billed by report, justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.

- Based on review of the Physician’s Initial Evaluation which details the injured worker’s medical history, current medications, physical examination including functional strength, range of motion, function movement and lifting, dynamic posture and stabilization, psychological evaluation, treatment plan and a formal request for authorization, procedure code 97799-86 is substantiated as the Provider documented services performed.
- Documents reviewed included the Physician Initial Evaluation, detailed FRP Musculoskeletal Evaluation and Psychological and Behavioral Evaluation
- The Provider’s Usual and Customary Fee is presented on Authorization Request dated 06/16/2014 as “Interdisciplinary Evaluation at cost of \$2,500.00.”
- Claims Administrator’s Approval letter of Initial Evaluation dated 07/14/2014 was also reviewed.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 97799-86 is warranted.

Date of Service: 8/21/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
97799-86	\$2,500.00	\$2,102.01	\$272.99	1	N/A	\$2,375.00	DISPUTED SERVICE: Additional reimbursement of \$272.99 is recommended

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