

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 30, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-000007	Date of Injury:	12/03/2011
Claim Number:	[Redacted]	Application Received:	01/02/2015
Claims Administrator:	[Redacted]		
Assigned Date:	1/27/2015		
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.

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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, MD, MPH
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
- Negotiated contracted rates:

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 code 97799-86 for three separate dates of service.
- Claims administrator reimbursed the dates of service indicating on the Explanation of Review “The recommended allowance is based on usual, customary and reasonable rates for this geographical area”
- 97799 has an unassigned value is a By Report code. Per General Information and Instructions Title 8 CCR §9789.11(a) (1): By Reports (BR) – Procedures coded BR are services which are unusual or variable. An unlisted service or one that is rarely provided, unusual or variable may require a report demonstrating the medical appropriateness of the service. In some instances, the values of BR procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.
- Functional Restoration Programs include a multitude of procedures which there does not appear to be a comparable code. Therefore, reimbursement is based on the report submitted by the provider along with the provider’s usual and customary charge less any PPO discount.
- Documentation submitted for this review included one request for authorization of FRP for 106 additional hours of FRP. Also included was three provider’s progress reports. The first report titled Discharge Report summarizes the five weeks of FRP for the injured worker. The second report titled Progress Report Week #2 stated the patient has currently

completed 64 authorized hours of FRP. Review #413190 Determination Date: 02/27/2014. A third and fourth report submitted state the same thing as the second report. No changes to details were found in the third and fourth report to dates of service and they also state there were 64 authorized hours from Review #413190 Determination Date: 02/27/2014.

- Also received documentation included Utilization Review #413190 approving 64 hours of FRP Trial between 2/21/2014-4/22/2014. A second Utilization Review #420611 showing ‘Appeal Review’ approving an additional 106 hours of FRP between 4/24/2014-7/23/2014. Review #420611 states that a re-review of Review #420126. Only the two UR’s were received for this review. No other UR’s were received for this review.
- Provider billed code 97799-86 on a CMS 1500 form with dates of service 3/31/2014-4/11/2014 for 64 hours. A second claim was submitted showing dates of service 4/14/2014-4/25/2014 for a total of 64 hours. A third claim submitted for dates of service 4/28/2014-5/2/2014 with a total of 32 hours.
- UR approved a total of 64 hours between dates of service 2/21/2014-4/22/2014. Provider used 64 hours between dates of service 3/31/2014-4/11/2014. 44.8 hours were used between 4/24/2014-5/2/2014. A total of 108.8 hours were used during the approved dates of service 2/21/2014 -4/22/2014 and 4/24/2014-7/23/2014. Provider’s Usual and Customary fee is documented as \$225/hour for FRP. $\$225.00 \times 108.80 = \$24,480.00$. Claims administrator reimbursed a total of \$25,081.60.
- Based on information submitted for this review, no further reimbursement is warranted for code 97799-86.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 97799-86 is not recommended.

Date of Service: 3/31/2014, 4/14/2014 and 4/28/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
97799-86	\$36000.00	\$25081.60	\$10918.40	160	N/A	\$24480.00	DISPUTED SERVICE: No further reimbursement is recommended.

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[REDACTED]