MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 8, 2015

[redacted]

IBR Case Number:	CB15-0000189	**Date of Injury:**	11/07/2013
Claim Number:	[redacted]	**Application Received:**	02/12/2015
Claims Administrator:	[redacted]	**Assignment Date:**	03/08/2015
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: 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 $195.00 for the review cost and $1,174.50 in additional reimbursement for a total of $1,369.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1,369.50 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., M.P.H.
Medical Director

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
- Partial PPO Contractual Agreement: 94%

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 11/24/2014 – 11/26/2014.**
- Claims Administrator denied FRP services stating, "This charge adjusted to comply with the rate and rules of the contract indicated."
- Functional Restoration Program service not in dispute.
- Payment for FRP is in dispute.
- Request for 160 Hours of FRP states the Providers Usual and Customary fee of $225.00 hour faxed to Claims Administrator by Provider on 10/06/2014 for dates of service 11/10/2014 – 12/19/2014.
- Authorization for FRP Initial Evaluation signed by Claims Administrator on October 06, 2014. Fee reflected on original request is not stated on the Authorization. Authorization does not indicate expiration date.
- Modifier -86: OMFS Modifier is used when prior authorization was received for services that exceed OMFS ground rules.
- Authorization for Functional Restoration Program presented for IBR, dated 10/06/2014 signed by the Claims Administrator, indicates treatment is "medically necessary" meeting the criteria for Modifier -86 met.
- OMFS allows for Unlisted Procedure Codes to be reimbursed by "By Report."

- §9789.12.4 (c) "In determining the value of a By Report procedure, consideration may be given to the value assigned to a **comparable** procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed."
- There is no allowance or comparable code listed under the OMFS for service billed with procedure code 97799 or, more specifically, a Functional Restoration Program; a CPT Code has yet to be formulated for this comprehensive program. As such, a contractual agreement or the OMFS will dictate the level of reimbursement.
- Partial PPO Contractual Agreement "Exhibit F" indicates lesser of 94% of billed charges or 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: 97799 - 86

Date of Service: 11/24/2014 – 11/26/2014							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
97799-86	$4,050.00	$2,632.50	$1,174.50	N/A	1	$3,807.00	PPO Contract – Reimbursed Amount = $1,174.50 Due Provider

Copy to:

[redacted]

Copy to:

[redacted]