

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

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 additional remuneration for Functional Restoration Evaluation services, billed as Unlisted Evaluation and Management Procedure Code 99499 for dates of service 06/29/2015 – 07/02/2015.**
- Claims Administrator reimbursed \$2912.00 with the following rationale: “Your bill(s) has been reduced based upon the recommendation of our review agency”
- Provider submitted documentation supporting Usual and Customary fee of \$1120/day billing with CPT 99499 with a modifier -86.
- Authorization signed by Claims Administrator on 06/10/2015 indicating “Modified to certify 12 days or 78 hours (program M-Th 8:30-3:00 per RFA).”
- Modifier -86: OMFS Modifier is used when prior authorization was received for services that exceed OMFS ground rules.
- CMS1500 reflects Modifier – 86 appended to Unlisted Procedure Code, meeting the OMFS Ground Rules.
- 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 99499 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. Authorization signed by Claims Administrator on 06/10/2015 is contract in nature.
- Based on guidelines and documentation reviewed, reimbursement for 99499 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99499

| Date of Service: 06/29/2015 – 07/02/2015 | | | | | | | |
|--|-----------------|--------------|----------------|----------------|-------|----------------------------|---------------------------|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Units | Workers' Comp Allowed Amt. | Notes |
| 99499 | \$4480.00 | \$2912.00 | \$1568.00 | N/A | 1 | \$3808.00 | \$896.00 due to Provider. |

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