MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 20, 2015

[redacted]

IBR Case Number:	CB15-0001940	Date of Injury:	01/12/2014
Claim Number:	[redacted]	Application Received:	10/19/2015
Assignment Date:	05/04/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	05/04/2015 – 05/08/2015		
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 $562.50 in additional reimbursement for a total of $757.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$757.50** 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
- Official Medical Fee Schedule
- Contractual Agreement

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 Evaluation services, billed as Unlisted Procedure Code 97799 -86, for date of service 05/04/2015 – 05/08/2015.**
- EOR indicate The Claims Administrator's reimbursement was based on Physical Medicine and contractual obligation.
- Modifier -86: OMFS "This Modifier is used when prior authorization was received for services that exceed 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 listed under the OMFS for the billed procedure code 97799 or, more specifically, an Functional Restoration Program Evaluation, and a comparable procedure code does not exist. The 97750 code re-assignment by the Claims Administrator does not adequately reflect the RVU's relating to the comprehensive service of a FRP.
- The Provider's Usual and Customary Fee is presented on the Authorization Request dated **05/01/2015** as "$225.00 per hour."

- Authorization for FRP dated 03/25/2015, Reference # 1521102, Start Date: 11/12/14, End Date: 6/26/2015, signed by Claims Administrator does not indicate a procedure coded and does not indicate agreement of charges but does agree to FRP and refers to as such, the OMFS or contractual agreement dictates reimbursement for 97799-86.
- Functional Restoration Program service is authorized meeting the criteria for Modifier -86.
- Recommend reimbursement for 1 unit of 97799-86 each representing dates of service 05/04/2015 – 05/08/2015.
- **California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11**: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code **shall not apply to the contracted reimbursement rates.** Except as provided in subdivision (b) of Section 5307.1, the official medical fee schedule shall establish maximum reimbursement rates for all medical services for injuries subject to this division provided by a health care provider or health care facility licensed pursuant to Section 1250 of the Health and Safety Code other than those specified in contracts subject to this section.
- The aforementioned Authorization is contractual in nature.
- Partial **Contractual Agreement** indicates **"95%"** for procedures codes **of "no assigned value**."
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 10/21/2015; response not yet received.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is not indicated for Unlisted Procedure Code 97799-86.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97799-86

Date of Service: 05/04/2015 – 05/08/2015							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
97799 - 86	$5,625.00	$4,781.25	$562.50	N/A	25	$5,353.75	PPO Contract $562.50 Due Provider

Copy to:

[redacted]

Copy to:

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