

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 remuneration for Functional Restoration Evaluation services, billed as Unlisted Evaluation and Management Procedure Code 99499-86, for date of service 11/03/2014 – 11/06/2014.**
- Claims Administrator denied reimbursement with the following rationale: "... if a flat rate agreement..., ... no documentation received..., By Report Code..., & Not in Provider's Scope of Practice..."
- Payment for FRP is in dispute.
- **Modifier -86:** OMFS Modifier is used when prior authorization was received for services that exceed OMFS ground rules.
- Authorization signed by Claims Administrator on 10/14/2014 for FRP "Begin 10/14/2014 End 01/12/2015 2 weeks @ Eighty Hours," meeting the criteria for Modifier -86.
- Provider's RFA reflects Usual and Customary Fee.
- Documentation Entitled "Progress Report for Week 1" reflects dates of service 11/3/2014 through 11/06/2014.
- 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.
- Contractual Agreement not available for IBR; signed Authorization by Claims Administrator does not indicate a “By Report” or PPO Reduction. As such, in absence of the actual contractual agreement, the signed authorization and the OMFS dictates reimbursement.
- **Pursuant to LC § 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**.
- Full contractual agreement not available for IBR.
- Opportunity to Dispute sent to Claims Administrator on 06/27/2015; response not yet received.
- The aforementioned 10/17/2014 Authorization is contractual in nature. As such, the contractual rates apply pursuant to LC §5307.11.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 97899-86

Date of Service 11/03/2014 – 11/06/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
99499	\$4,480.00	\$0.00	\$4,480.00	N/A	1	\$4,480.00	Refer to Analysis

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