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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 7, 2016

[redacted]

IBR Case Number:	CB15-0002276	Date of Injury:	06/27/2013
Claim Number:	[redacted]	Application Received:	12/14/2015
Claims Administrator:	[redacted]		
Date(s) of service:	08/18/2015		
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 $1,583.34 in additional reimbursement for a total of $1,778.34. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,778.34** 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: 95%

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 Initial Interdisciplinary Evaluation service, billed as Unlisted Procedure Code 97799-86 for date of service 08/18/2015.**
- The Claims Administrator based reimbursement on the "This charge was adjusted to comply with the rate and rules of the contract indicated."
- Request for Authorization dated 7/23/2015 indicates "Service/Good Requested: Initial Evaluation FRP, CPT/HCPCS: 97799 x1, This is a formal request for an Initial Interdisciplinary Evaluation at cost $2,500.00"
- Modifier -86: OMFS Modifier is used when prior authorization was received for services that exceed OMFS ground rules.
- Certification for "initial evaluation Functional Restoration Program x1 for right shoulder/Approved by Physician Advisor" from Claims Administrator. CPT/HCPCS and Provider's charge from RFA were not documented on Claims Administrator's Authorization.
- EOR's indicate services "authorized," meeting the criteria for modifier -86.
- 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." The

Physical Therapy reimbursement rational assigned by the Claims Administrator is not a comparable comparison for this type of Program.

- 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 multispecialty program. As such, a contractual agreement or the OMFS will dictate the level of reimbursement.
- Submitted **Contractual Agreement** for Workmens' Compensation "For covered services billed with a procedure code for which there is no assigned value in Sections 4a or 4b above, Provider shall be reimbursed at **95%** of Eligible Billed Charges**"**
- **CCR § 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**.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 97799-86 at contractual rate.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97799 - 86

Date of Service: 08/18/2015							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
97799-86	$2500.00	$791.66	$1,583.34	N/A	1	$2,375.00	**$1,583.34** Due Provider

Copy to:

[redacted]

Copy to:

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