

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 11, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000076	Date of Injury:	04/01/2008
Claim Number:	[REDACTED]	Application Received:	01/15/2016
Assignment Date:	02/04/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/10/2013 – 07/10/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	97670-30-86		

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 \$991.25 in additional reimbursement for a total of \$1,186.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$1,186.25** 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]
[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
- OMFS

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 97670 - 32 Functional capacity measurement (e.g., combination of standardized tests of strength, flexibility, weight lifting, weight carrying, and pushing and pulling movements to determine functional ability); including report; requires prior authorization for date of service 07/10/2013.**
- EOR's reflect the following:
 - 1st EOR: 1) Pre-Authorization Required 2) Authorization Number Invalid or Missing.
 - 2nd EOR: 1) Reimbursement of \$403.75 2) per Pre-Authorization and Labor Code.
 - 01/04/2016 Final EOR: 1) Pre-Authorization Required 2) Documentation Does not support a significant and identifiable E&M Service 3) Per LC 5307.1
- CMS 1500 reflects the following:
 - Original and Subsequent HCFA - Authorization Number not reflected in box 23.
 - CPT 97670-30-86-WP – Original CMS 1500
 - CPT 97670-WP – SBR submission
- Modifiers listed on CMS 1500 that are not relevant to case; supportive documents not submitted for IBR:
 - 30 - Consultation Service During Medical Legal Evaluation
 - 32 – Mandated Consultation
 - WP – Whole Procedure or Impairment Rating – Not relevant to California Specific Billing Codes.
- Relevant Modifier: 86 – “This Modifier is used when prior authorization was received for services that exceed OMFS ground rules.”
- **Authorization dated 07/27/2013**, Authorization Number: FICMTCAD0000036790, reflects the following: "**Referral to (Provider) for FCE** for the cervical spine." Authorized through **06/27/2013 To 09/25/2013**.
- **Requirement Met** for Modifier -86.
- **OMFS Physical Medicine General Instructions 97670 Code Description:** Functional capacity measurement (e.g., combination of standardized tests of strength, flexibility, weight lifting, weight carrying, and pushing and pulling movements to determine functional ability); including report; requires prior authorization.
- **Prior Authorization Requirement Met** for OMFS 97670 code Description.
- 97670 is a By Report Code; there is no unit value.
- 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 97670 or, more specifically, a Functional Capacity examination and a comparable procedure code does not exist.
- In absence of a Contractual Agreement, the OMFS allows reimbursement based on the Provider's Usual and Customary charge.

- Opportunity to Dispute communicated to Claims Administrator on 01/19/2016; response not yet received.
- Contractual Agreement not submitted for IBR.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 97670 x 1 unit.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97670

Date of Service: 07/10/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
97670	\$1,395.00	\$403.75	\$1,395.00	1	\$1,395.00	\$991.25 Due Provider Refer to Analysis

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