

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 22, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000893	Date of Injury:	01/29/2014
Claim Number:	[REDACTED]	Application Received:	05/31/2016
Assignment Date:	06/21/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/11/2106 – 01/14/2016		
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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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,

MAXIMUS

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
- 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 Procedure Code 97799 -86, for date of service 01/11/2016 – 01/14/2016.**
- Opportunity to Dispute Eligibility communicated with the Claims Administrator on 06/01/2016; response received 06/09/2016. The Claims Administrator submitted communication indicating the following:
 - “The Provider is in agreement of their (Network) contract however, they are disputing the benefits and stating the claim should be (priced) according to their contract with (Claims Administrator). As this is a policy/payment issue rather than a network issue, (Plan Administrator), will need to educate the Provider regarding the member’s policy and what they have access to in regards to the network and benefits.”
 - “The dispute in this matter arises out of **which PPO contract...**”
- **California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:** 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.

- Contractual disputes of this nature (refer to Claims Administrator's response above) are unable to be resolved through IBR.
- **Administrative Rules Article 5.5.0. § 9792.5.7.** Requesting Independent Bill Review (b) Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or **the applicability of a contract for reimbursement rates under Labor Code section 5307.11** shall be resolved before seeking independent bill review.
- **Based on the aforementioned documentation and guidelines, 97799 determination is Upheld.**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 97799-86

Date of Service: 01/11/2016 – 01/14/2016							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
97799 - 86	\$6,075.00	\$5,163.75	\$607.50	N/A	27	\$5,163.75	Refer to Analysis

Copy to:

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