

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 5, 2015

[Redacted]

IBR Case Number:	CB14-0001866	Date of Injury:	03/29/2011
Claim Number:	[Redacted]	Application Received:	12/03/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/6/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99499		

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 \$250.00 for the review cost and \$1875.95 in additional reimbursement for a total of \$2125.95. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2125.95 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, MD, MPH  
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
- Negotiated contracted rates: PPO Contract
- National Correct Coding Initiatives
- Other: 2014 CPT Guidelines

## 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 is dissatisfied with reimbursement of code 99499.
- Claims administrator reimbursed \$374.05 indicating on the Explanation of Review “The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.” Claims administrator’s comparable code is 97750 – Physical Performance Test.
- Provider’s report submitted documents Medical Evaluation including History of Present Illness, Previous Diagnostic Studies, Present Pain Complaints, Current Medications and Musculoskeletal Evaluation. Page 4 of the report documents a Psychological Evaluation including Mental Status Evaluation, Impact of Pain on Different Aspects of Functioning, Diagnostic Psychological Testing, The Beck Depression Inventory (BDI), Patient Disability Questionnaire, The Million Behavioral Medicine Diagnostic, Diagnostic Impression and a Final Discussion, Conclusion, Functional Restoration Program Treatment Plan, Functional Goals of Treatment and a Formal Request for Authorization for the Functional Restoration Program 97799x64. Provider documents 30 minutes face-to-face interview with the injured worker and 60 minutes for the psychological evaluation. Additional 120f minutes were spent reviewing medical records.
- 97750 is a physical performance testing or functional capacity evaluation which measures physical strength, range of motion, stamina, and tolerance to functional activities including lifting and carrying. This does not include the psychological evaluation as the

Functional Restoration Program does for which the provider is evaluating as per his report. Therefore, 97750 would not be a comparable code for 99499.

- 99499 is a code has an unassigned value. Per PPO contract received, under Workers' Compensation Product, Appendix B, #B: Reimbursement for services that are billed with a procedure code for which there is no assigned value for that Product as outlined above shall be reimbursed at 90% of Provider's billed charges.
- Based on information reviewed, additional reimbursement of code 99499 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 99499 is recommended.

Date of Service: 8/27/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99499-AG	\$2500.00	\$374.05	\$2125.95	1	N/A	\$2250.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1875.95

Copy to:

[REDACTED]

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