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 $1203.60 in additional reimbursement for a total of $1453.60. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1453.60 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.
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
- National Correct Coding Initiatives
- Other: OMFS Physicians 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 dissatisfied with reimbursement of code 97799-86
  - Provider was reimbursed $2857.65 and is seeking additional reimbursement of $1,203.60.
  - The Official Medical Fee Schedule and CPT 2014 Edition were reviewed
  - CPT code 97799 has a Physician Fee Schedule status indicator “C.”.
  - If payable, status code “C” will be paid “By Report”, generally following review of documentation such as an operative or progress report.
  - CCR 9789.12.4 “By Report” - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs
    - (a) An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report (report not separately reimbursable), justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.
    - (b) (1) In accordance with section 9789.12.3, when procedures with status indicator codes C, N, or R, do not have RVUs assigned under the CMS’ National Physician Fee Schedule Relative Value File, these services shall be billed by report, justifying that
the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.

- Medical records, authorization requests and authorizations submitted and reviewed, indicated services functional restoration services provided were authorized for dates of service 8/4/2014-8/08/2014. Provider documented 19 Program hours completed in Week six with a total cumulative hours completed as 148. Medical record for the treatment dates of 8/4/2014-8/8/2014 documented the worker’s progress which included: medical, psychological and physical/functional; psychological progress and physical/functional progress charts.

- Also included was the Request for Authorization of Medical Treatment for 160 hours of Functional Restoration Program documenting Provider’s cost at $225.00 an hour.

- Claims Administrator’s Approval letter for 80 hours dated June 16, 2014 and an additional 80 hours on July 22, 2014 was noted. A total of 160 hours of FRP was approved.

- Functional Restoration Programs are a type of treatment included in the category of interdisciplinary pain programs. Functional Restoration Programs are designed to use medically directed, interdisciplinary pain management approaches geared specifically for patients with chronic disabling occupational musculoskeletal disorders.

- Based on review of the FRP Weekly Progress Report stating the injured worker’s treatment for the week, along with the Physical Therapy Progress Report, Physician’s Progress Report, Psychological and Behavioral Progress Note which detail the comprehensive and intense pain program this injured worker is completing, procedure code 97799-86 is substantiated as the Provider documented services performed.

- Based on information reviewed, additional reimbursement of code 97799-86 is warranted.

- PPO Contract discount shows a 5% discount is to be applied.
The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 97799-86 is warranted.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Provider Billed</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Assist Surgeon</th>
<th>Units</th>
<th>Workers’ Comp Allowed Amt.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>97799</td>
<td>$4275.00</td>
<td>$2857.65</td>
<td>$1,203.60</td>
<td>N/A</td>
<td>1</td>
<td>$4061.25</td>
<td>DISPUTED SERVICE- Additional reimbursement of $1203.60</td>
</tr>
</tbody>
</table>