

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001160	Date of Injury:	02/9/2012
Claim Number:	[REDACTED]	Application Received:	08/18/2014
Claims Administrator:	[REDACTED]	Assignment Date:	09/24/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	90837 x 4 units DOS 02/20/2014, 03/016/2014, 03/20/2014 and 04/03/2014		

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 \$167.04 in additional reimbursement for a total of \$417.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$417.04 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,

[REDACTED]

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
- Official Medical Fee Schedule
- CCI Edits - Policy Narratives (01/01/2014): Chapter I General Correct Coding Policies, Excerpt - Section E

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 90837 Psychotherapy, **60 minutes** x 4 units for dates of service: 02/20/2014, 03/16/2014, 03/20/2014 and 04/03/2014.
- Claims Administrator denied 90837 service stating: “Per CCI Edits, the value of this procedure is included in the value of the comprehensive procedure.”
- 90837, is paired to billed code 90901, biofeedback training by any modality.
- NCCI edits reveal 90901 is Colum 1 Code when billed with Colum 2 Code, 90901.
- Under certain circumstances, the paired codes in question may be unbundled with the use of modifier -59. NCCI Edits state, “Modifier 59: Modifier 59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. The CPT Manual defines modifier 59 as follows: Modifier 59: **Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services other than E/M services that are not normally reported together, but are appropriate under the

circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59.' ”

- Documentation of 02/20/2014, 03/16/2014, 03/20/2014 and 04/03/2014. Patient encounters included **one** PR-2 report listing the dates in question. Documentation indicates “time spent in session 60 min,” for all four listed dates.
- Separately Identifiable service, over and above 90837 60 min service could not be identified.
- Claims Administrator Reimbursed Provider for 90901 on all dates of service.
- Only 90837 services are clearly identified in documentation.
- Based on the aforementioned guidelines, reimbursement is recommended for 4 units of 90837.
- Contractual Agreement requested on 09/24/2013 not yet received during IBR. As such, reimbursement rate could not be identified. OMFS will be utilized to calculate reimbursement.
- EOR reflects Provider Reimbursed 4 units of 90901 @ \$58.24 = \$232.96
- Authorization for services dated February 25, 2014 states “Cognitive Behavioral Sessions,” and “Biofeedback Therapy Sessions,” X6 as “Certified.”
- Recommend reimbursement for 90876, “Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes,” as code best describes authorized service.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 90837

Date of Service: 02/13/2014; 02/18/2014; 03/04/2014; & 04/01/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
90837 as 90876	\$400.00	\$232.96	\$400.00	N/A	4	\$400.00	\$400.00 – \$232.96 = \$167.04 Due Provider
90901	N/A	N/A	N/A	N/A	N/A	N/A	Not In Dispute

Copy to:

[REDACTED]

Copy to:

[REDACTED]