

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 25, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001926	Date of Injury:	09/07/2012
Claim Number:	[REDACTED]	Application Received:	12/15/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/22/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	90837-59		

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 \$143.83 in additional reimbursement for a total of \$393.83. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$393.83 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]  
[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:
- National Correct Coding Initiatives

## 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 denial of code 90837-59
- Claims administrator denied code indicating on the Explanation of Review “Service/item included in the value of other services per CCI edits. Related service could be on a separate bill.” No separate bill containing code 90837 was received for this review.
- CPT 90837 - Psychotherapy, 60 minutes with patient and/or family member.
- Pursuant CMS Special Edition article for psychotherapy services provided without an E&M service, the correct code depends on the time spent with the beneficiary. In general, providers should select the code that most closely matches the actual time spent performing psychotherapy. CPT® provides flexibility by identifying time ranges that may be associated with each of the three codes: Code 90832 (or + 90833): 16 to 37 minutes, Code 90834 (or + 90836): 38 to 52 minutes, or Code 90837 (or + 90838): 53 minutes or longer
- Provider billed codes 90837-59 and 90901 on a CMS 1500 form. Per NCCI edits, generally these two codes are not billed together. However, Modifier Indicator column shows a ‘1’ which states as long as provider billed the correct code with an acceptable modifier and documentation supports the code billed then billing is appropriate. Provider did bill code 90837 with a modifier -59 which is one of the acceptable modifiers and documentation from the provider’s PR-2 report states “time spent in session 53 minutes”.
- Based on documentation reviewed, reimbursement of code 90837-59 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

<b>Date of Service:</b> 3/20/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
90837-59	\$175.00	\$0.00	\$175.00	1	N/A	\$143.83	<b>DISPUTED SERVICE:</b> Allow reimbursement \$143.83

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier Allowed</b>
Physician Version Number: 20.0	90901	90837	Yes

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