

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 8, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB15-0000021	<b>Date of Injury:</b>	11/26/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	01/09/2015
<b>Claims Administrator:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	96101 x 12 units, 96116 x 2 units		

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,

Paul Manchester, MD  
Chief Coding Reviewer

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: Not available
- National Correct Coding Initiatives
- Other: OMFS Physician's 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 remuneration for CPT 96101 Psychological Testing x 12 units and 96116 Neurobehavioral Status Exam x 2 performed during New Patient Evaluation of Injured Worker on 10/01/2014.**
- Claims Administrator Reimbursement Rational: DWC Adjustment Code G10, “We cannot review this service without necessary documentation. Please resubmit with indicated documentation as soon as possible.”
- Pursuant Title 8 CCR Physician Fee Schedule 1/1/2014, § 9789.12.13 Correct Coding Initiative: (a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
- CMS 1500 form reflects 96101 x 12 units, 96116 x 2 units billed with Evaluation and Management Code 99205.
- Based on the NCCI edits code pair exist between CPT 99205 and 96101; and 99205 and 96116.
- Modifier Indicator column shows ‘1’ which states if a proper modifier is appended to the correct code and documentation supports the use of the procedure code then the edit may be overridden.
- A modifier was not appended to the column 2 codes: CPT 96101 or 96116, as such the codes may not be reviewed as a separate service from its code pair.
- Signed Authorization from the Claims Administrator or Legal Parties specifically requesting Psychological and/or Neurobehavioral testing for date of service 10/01/2014 could not be identified within the documentation.
- Based on the aforementioned documentation and guidelines, reimbursement is not warranted for 96101 x 12 units or 96116 x 2 units.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 96101 x 12 units and 96116 x 2 units.**

<b>Date of Service:</b> 10/01/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
96101	\$1,800.00	\$0.00	\$1600.00	N/A	N/A	\$0.00	<b>Refer to Analysis</b>
96116	\$300.00	\$0.00	\$300.00	N/A	N/A	\$0.00	<b>Refer To Analysis</b>
99205	N/A	N/A	N/A	N/A	N/A	N/A	<b>Service Not in Dispute</b>

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Physician Version Number: 20.2	99205	96101	Allowed
Physician Version Number: 20.2	99205	96116	Allowed

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]