

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 reimbursement of 99205 and denial of 96101
- Claims Administrator denied code 96101 indicating on the Explanation of Review “Per CCI Edits, the value of this procedure is included in the value of the comprehensive procedure”
- Provider billed code 96101 along with CPT 99205 which was reimbursed.
- As a pair code exists between billed codes 96101 and 99205, these two code generally are not billed together. However, if an approved modifier were appended to the appropriate code, and documentation supports billed code then the edit may be overridden.
- Provider did not bill 96101 with a modifier and therefore was not billed correctly. Reimbursement of 96101 is not warranted.
- Provider is also dissatisfied with reimbursement of billed CPT code 99205 changed to 99215. Claims Administrator indicated on the Explanation of Review “The provider has previously billed for an initial visit therefore the procedure code has been changed to a follow up visit”
- Provider’s Psychological Consultation Report/Request For Treatment Authorizaiton states: “I examined the injured worker in person at my office on September 10, 2014 and October 7, 2014.”

- Claims Administrator does not deny the components were not met, only the established patient, not a new patient as 99205 mandates: 99205 - Office or other outpatient visit for the evaluation and management of a **new patient**.
- As provider does not deny the Claims Administrator's reason for the change in code as an established patient, nor does the Provider document in his report if the patient is a new patient, reimbursement of 99205 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 99205 and 96101

Date of Service: 10/7/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99205	\$700.00	\$167.15	\$70.52	1	N/A	\$167.15	DISPUTED SERVICE: No reimbursement is recommended
96101	\$893.86	\$0.00	\$893.86	8.5	N/A	\$0.00	DISPUTED SERVICE: No reimbursement is recommended

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.3	99205	96101	Allowed

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