

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 13, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001117	Date of Injury:	04/12/2014q
Claim Number:	[REDACTED]	Application Received:	07-10-2015
Assignment Date:	07/30/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/28/2014 – 10/28/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	96101		

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, M.D., M.P.H.
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: 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 96101 Psychological Services performed on 10/28/2014.**
- Claims Administrator Reimbursement Rational: “Per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure.”
- Authorization for “Psychiatric Evaluation Approved 10/03/2014.” Med-Legal status not indicated, standard “Utilization and Review” is indicated.
- QME Report not submitted for IBR.
- Communication for Legal Parties not submitted for I BR.
- **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 pertinent code 99205,
- EOR Reflects code change to 99215
- Based on the NCCI edits code pair exist between CPT 99205 and 96101.
- Based on the NCCI edits code pair exist between CPT 99215 and 96101
- 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.
- Reimbursement is not recommended for the billed codes 96101 or 96116.
- Article 5.5.0. Rules For Medical Treatment Billing and Payment §9792.5.7. Requesting Independent Bill Review (b)(2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 96101.

Date of Service: 10/28/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
96101	\$736.12	\$ 0.00	\$736.12	N/A	N/A	\$0.00	Refer to Analysis

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
code pairs found in Physician Version 20.3 (10/1/2014-12/31/2014)	99215	96101	Allowed
code pairs found in Physician Version 20.3 (10/1/2014-12/31/2014)	99205	96101	Allowed

Copy to:

[REDACTED]

Copy to:

[REDACTED]