

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001199	Date of Injury:	07/18/2010
Claim Number:	[Redacted]	Application Received:	07/27/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	11/12/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99205, 99354, WC007, and 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: 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 \$195.00 for the review cost and \$225.79 in additional reimbursement for a total of \$420.79. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$420.79 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 codes 99205, 99354, WC007-30, and 96101
- Claims Administrator denied code 99205 indicating on the Explanation of Review “Determination based upon The National Correct Coding Initiative Edits (NCCI) adopted by the CMS. Based on the documentation submitted this service is unbundled from 90791 and therefore not separately payable. See bill 8584183”
- Provider billed codes 99205, 99354, 90785, WC007-30, 99199, WC008, 96101 and 99090 on a CMS 1500 form. CPT code 90791 was not a billed code.
- Effective 1/1/2014 - § 9789.12.12 Consultation Services Coding—use of visit codes: (a) Maximum fees for physicians and qualified non-physician practitioners performing consultation services shall be determined utilizing the appropriate RVU for a patient evaluation and management visit and the RVU(s) for prolonged service codes if warranted under CPT guidelines. Physicians and qualified non-physician practitioners shall code consultation visits as patient evaluation and management visits utilizing the CPT Evaluation and Management codes that represent where the visit occurs and that identify the complexity of the visit performed. CPT consultation codes shall not be utilized.
- (2) In the office or other outpatient setting where a consultation / evaluation is performed, physicians and qualified non-physician practitioners shall use the CPT visit codes

(99201–99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician, as defined in section 9789.12.11.

- The Provider’s report titled Psychological Consultation Report/Request for Treatment Authorization documents an exam he performed on the patient.
- Reimbursement of 99205 is warranted.
- Provider billed code 99354 for prolonged services. Provider’s report does not document a start and stop time, nor a total time spent with the patient.
- Reimbursement of 99354 is not warranted.
- Provider’s WC007-30 was denied by Claims Administrator indicating on the Explanation of Review “This report does not appear to be requested by the AD, WCAB, AME and/or QME. Please submit the request from an authorized entity with the appropriate modifier. Refer to CCR 9789.14”
- Provider’s request for a re-evaluation dated May 20, 2015 states “As per Title 8, CCR, 9789.12.1, et seq. (Section §9789.14(b)(5)), our report qualify as a consultation report requested by the QME or AME. Please find enclosed a copy of QME Dr. referral to this office for consultation”
- Notice of Referral submitted states “Referral Reason: Psychological Evaluation”
- Notice only requests a psychological evaluation, not a report. Referral Notice does not appear to be requested by an AME or QME, but by the Primary Treating Physician.
- Reimbursement of WC007-30 is not warranted.
- The final code in dispute is 96101 – psychological testing.
- As code pair exists between 99205 and 96101, Provider did not bill code 96101 with a proper modifier required by NCCI.
- Reimbursement of 96101 is not warranted.
- EOR reflects a 5% PPO reduction to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99205

Date of Service: 11/12/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
99205	\$700.00	\$0.00	\$700.00	1	N/A	\$225.79	DISPUTED SERVICE: Allow reimbursement \$225.79

National Correct Coding Initiative information:

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

Copy to:

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[REDACTED]

Copy to:

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