

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 5, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000352	Date of Injury:	09/30/2002
Claim Number:	[REDACTED]	Application Received:	03/01/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/05/2014 – 03/25/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	90853		

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

[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
- Medicare Billing Manual
- NCCI Edits
- AMA CPT
- OMFS

## **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 90853 submitted for dates of service 11/05, 11/19, 11/26, 12/03, 12/10, 2014, 01/07, 01/14, 01/21, 01/28, 02/04, 02/11, 02/18, 03/04, 03/09, 03/18 & 03/25 2015.**
- The Claims Administrator denied reimbursement stating “charge was made for a separate procedure that does not meet the criteria for separate payment.”
- Additional services included Hypnotherapy, NCCI Edit to 90853.
- CMS 1500 reflects Modifier -59 appended to 90853 indicating a separate procedure from other services also submitted for reimbursement on 11/05/2014 through 03/25/2015.
- Provider submitted a list comprised of three CPT codes; 2 were initialed by the Injured Worker to indicate services were performed. This initialed and dated documentation does not indicate that the requirements for 90853 were fulfilled in accordance with the code description as defined in the American Medical Association Current Procedural Terminology Code Book or NCCI Edits.
- **Administrative Rules § 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.
- **Medicare Billing Manual, Page I6, paragraph 1:** Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an **NCCI-associated modifier**, both the column one and column two codes are eligible for payment.
- **NCCI Edits versions 20.3, 21.0, 21.1, 21.3, & 21.3 reveal the following:**

▭ short description for column 1 code

Column 1	Column 2	*CCI Edit Description	Modifier Indicator	Effective Date
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▭ short description for column 2 code

▭ HYPNOTHERAPY

<u>90880</u>	<u>90853</u>	*Misuse of column two code with column one code	0	10/30/2000
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▭ GROUP PSYCHOTHERAPY

- A **modifier indicator of “0”** indicates that **NCCI-associated modifiers cannot** be used to bypass the edit. There is no NCCI associated modifier to unbundle modifier indicator of “0.”
- **Based on the documentation submitted, reimbursement for 90853 services is not indicated.**

The table on page 4 describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 90853**

**Date of Service:** 11/05, 11/19, 11/26, 12/03, 12/10, 2014, 01/07, 01/14, 01/21, 01/28, 02/04, 02/11, 02/18, 03/04, 03/09, 03/18 & 03/25 2015.

Provider Services

<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
90853	\$1,936.00	\$0.00	\$1,936.00	1	\$0.00	<b>Refer to Analysis</b>

[REDACTED]

[REDACTED]