

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/9/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000619	Date of Injury:	03/10/2003
Claim Number:	[REDACTED]	Application Received:	10/18/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/07/2013 – 03/07/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	90862, 96100, 96100		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/27/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$100.50, for a total of \$435.50**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed - The following evidence was used to support the decision:

- 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 or negotiated contract:
- Other: PPO Contract, American Medical Association Current Procedural Terminology 1997

Supporting Analysis:

Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.

The dispute regards the denial of billed charges for date of service 03/07/2013. The Provider is disputing \$0.00 reimbursement by the Claims Administrator for the following CPT Codes: CPT 90862, 96100 and 96100.

Definitions for the codes in question, as per the American Medical Association Current Procedural Code Book 1997 are:

- **CPT 90862** Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
- **CPT 96100** Psychological testing (includes psycho diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, PPPI) with interpretation and report, per hour

Claims Administrator denial code descriptions are as follows:

CPT 90862: 1) This charge was adjusted to comply with the rate and rules of contract indicated.
2) No separate payment was made because the value of the services is included within the value of another service performed.

CPT 96100: 1) This charge was adjusted to comply with the rate and rules of contract indicated.
2) Documentation of time spent performing this service is needed for further review.

On September 5, 2013, the Provider supplied additional information to the Claims Administrator for the codes in question. The "time spent" for CPT, per the Provider's communication to the Claims Administrator for CPT 96100 is, "Beck Depression Inventory 30 minutes," and "Beck Anxiety Inventory 30 minutes."

Upon review of the documentation provided for CPT 90862, it is indicated that the Provider discussed psychiatric related medication with the patient. According to the documentation, the patient is taking, "Sertraline (Zoloft) 100 mg a day, Wellbutrin XR 150 mg two a day, and a new trial of Abilify 2mg, one at night." In the Assessment and Plan portion of the progress note, the provider discusses the tapering of Abilify medication and a "6" week follow up appointment. Ibuprofen, Vicodin, hypertension and another (illegible) medication were also discussed. Based on these findings, CPT 90862 meets the criteria for Pharmacologic Management and reimbursement is recommended.

CPT 96100 was billed by the Provider two times. According to the documentation provided, two psychiatric questionnaires – anxiety and depression, were completed by the patient and then scored and interpreted by the provider. The relevant findings are documented in both the PR2 report and the service report for CPT 96100. In a letter from the Provider to the Claims Administrator, each report

takes “30 minutes” to complete. Compare this statement with the CPT 96100 description, this code should only have been billed one time and reimbursed one time as the code is “per hour,” not “per report.” It is recommended, therefore, that CPT 96100 be reimbursed one time.

Conclusion:

Given the aforementioned guidelines and analysis, the additional reimbursement of \$100.50 for Official Medical Fee Schedule CPT Codes 96100 and 90862 is warranted based on the following calculation:

PPO Contract - Workers Compensation Provider shall be reimbursed the lesser of the following:

80% of billed Charges

95% of usual, customary and reasonable (UCR) prevailing rates

95% of the current applicable federal or state mandated fee schedule

CPT 90862: Allowance was calculated as 95% of OMFS (billed charges exceed OMFS allowance)
 $\$50.43 \text{ (OMFS allowance)} \times .95 \text{ (PPO Contract)} = \47.91

CPT 96100 x 2 (units): Allowance was calculated as 80% of billed charges (OMFS allowance exceeds billed charges)
 $\text{Billed charges } \$65.74 \times .80 \text{ (PPO Contract)} = \52.59

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
90862	1	\$75.00	\$47.91	\$0.00	\$47.91	PPO Contract
96100	2	\$65.74	\$52.59	\$0.00	\$52.59	PPO Contract

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 90862, 96100 (\$100.50) for a total of \$435.50

The Claims Administrator is required to reimburse the provider \$435.50 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers’ Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

██████████, RHIT
 Chief Coding Reviewer

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]