

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

Independent Bill Review Final Determination Reversed

9/8/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000032	Date of Injury:	2/13/2009
Claim Number:	[REDACTED]	Application Received:	1/9/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/2/2013 – 6/5/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	90841		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/24/2014, 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 \$0.00, for a total of \$335.00.**

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: OMFS
- Other: OMFS Physicians Services, Rules, Guidelines and Ground Rules, AMA CPT

Supporting Analysis:

The dispute regards the denial of psychotherapy services (90841) performed on dates of service ranging from 5/2/2013 thru 6/5/2013. The Provider billed CPT 90841 for 5 (five) sessions on 5/2/2013; 5/9/2013; 5/16/2013; 5/23/2013; and 6/5/2013. The initial explanation of review indicated a denial of the billed CPT 90841 for dates of service 5/2/2013 thru 6/5/2013 with the explanation "The charge was adjusted to comply with the rate and the rules of the contract indicated." The final/second explanation of review in response to the Provider's appeal indicated a denial for each date of service in dispute with the following explanation "The payment of this service is determined by-report or by a report. This charge exceeds the Official Medical Fee Schedule allowance. The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance. This appears to be a duplicate charge for a bill previously reviewed, or this appears to be a "balance forward bill" containing a duplicate charge and billing for a new service."

MAXIMUS received notification from the Claims Administrator indicating that an additional amount of \$327.95 was paid for the psychotherapy services for dates of service 5/2/2013 thru 6/5/2013. The additional payment by the Claims Administrator was issued on or after the Independent Bill Review case was received by MAXIMUS. The IBR application was received on 1/9/2014. The additional payment of \$327.95 was issued on 1/9/2014. The explanation of review issued on 1/9/2014 indicated a reimbursement of \$65.59 and PPO discount of \$2.03 was applied to each billed service of CPT 90841 for dates of service 5/2/2013 thru 6/5/2013.

1997 AMA Current Procedural Terminology (CPT) code definitions:

CPT 90841: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face to face with the patient); time unspecified.

The description of the billed procedure code 90841 is "Unlisted procedure, skin, mucous membrane and subcutaneous tissue. Per the Official Medical Fee Schedule, the procedure code 90841 does not have an assigned unit value and is considered a "By Report" code. Per the OMFS Surgery General Information and Ground Rules, procedures coded By Report are services which are unusual or variable. An unlisted service, or one that is rarely provided, unusual or variable, may require a report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature or extent, and need for the procedure and the time, effort and equipment necessary to provide the service. By Report procedure values may also be determined by using the values assigned to a comparable procedure.

The Provider submitted an Activity Form for Services for the following dates of service: 5/2/2013; 5/9/2013; 5/16/2013; 5/23/2013; and 6/5/2013. Each Activity Form documented the following: Memos, Progress Notes & Other Procedures; Subjective Emotional and Physical Complaint Check List; Objective Finding Check List; Work Status and Assessment. The Activity Form sheet did not indicate the number of hours or minutes spent face-to-face with the injured worker. Time is a critical element when coding and billing Individual Psychotherapy services. The progress notes, findings and assessment did not provide a detailed report on the services provided in order to determine an allowance higher than the Claims Administrator's reimbursement of \$65.59 per visit.

OMFS lists the following codes for Individual Medical Psychotherapy as per 1997 AMA Current Procedural Terminology (CPT) code definitions:

CPT 90841: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face to face with the patient); time unspecified.

CPT 90842: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face to face with the patient); approximately 75 to 80 minutes

CPT 90843: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face to face with the patient); approximately 20 to 30 minutes

CPT 90844: Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including insight oriented, behavior modifying or supportive psychotherapy (face to face with the patient); approximately 45 to 30 minutes.

Due to the missing documentation of actual time spent with the injured worker and corresponding documentation, reimbursement is recommended for the Individual Medical Psychotherapy based on CPT 90843 (OMFS allowance \$59.66).

Based on the documentation submitted, additional reimbursement was warranted for the Official Medical Fee Schedule code 90841 (reviewed as 90843). The Claims Administrator's reimbursement issued on 1/9/2014 exceeded the recommended allowance of \$298.30. Due to the additional reimbursement was paid prior to the IBR Final Determination decision the only amount due by the Claims Administrator is the IBR application fee of \$335.00.

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

Validated Code	Date of Service	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
90843	05/02/2013	1	\$195.00	\$59.66	\$65.59	\$0.00	OMFS
90843	05/09/2013	1	\$195.00	\$59.66	\$65.59	\$0.00	OMFS
90843	05/16/2013	1	\$195.00	\$59.66	\$65.59	\$0.00	OMFS
90843	05/23/2013	1	\$195.00	\$59.66	\$65.59	\$0.00	OMFS
90843	06/05/2013	1	\$195.00	\$59.66	\$65.59	\$0.00	OMFS

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 90841 x 5 (units) (\$0.00) for a total of \$335.00.

The Claims Administrator is required to reimburse the provider \$335.00 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

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