

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 31, 2014

[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|--------------|------------------------------|------------|
| IBR Case Number: | CB14-0001499 | Date of Injury: | 12/10/2011 |
| Claim Number: | [Redacted] | Application Received: | 10/07/2014 |
| Claims Administrator: | [Redacted] | Assignment Date: | 11/07/2014 |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 90837 | | |

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 \$250.00 for the review cost and \$0.00 (unless provider has not been reimbursed \$943.50 as disputed amount) in additional reimbursement for a total of \$250.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$250.00 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,

[Redacted]
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: PPO Contract Discount 5%
- 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 code 90837 for multiple dates of service.
- Claims Administrator denied codes indicating on the Explanation of Review “CPT code submitted is based on service time and documentation does not support the time spent on this procedure.”
- 90837 - Psychotherapy, 60 minutes with patient and/or family member.
- Provider submitted treatment notes which clearly states time spent with patient as “60 min face-to-face”
- Based on information reviewed, reimbursement of code 90837 is warranted.
- Documentation received from Claims Administrator dated October 31, 2014 states “CPT 90837 have been overturned, additional payment was issued to the provider on 10/30/2014 in the amount \$943.52 which equals the providers IBR request amount of \$993.16 – 5% (PPO agreement) = \$943.52”
- A copy of the check was not submitted for review, nor was the Explanation of Review for services paid. If provider has been reimbursed the amount in dispute, then Claims Administrator is only responsible for the IBR application fee of \$250.00.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 90837 is recommended.

| Date of Service: 1/16, 1/23, 1/30, 2/13, 2/27, 3/13, 3/20 and 3/27 | | | | | | | |
|--|-----------------|--------------|----------------|-------|------------------|----------------------------|--|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 90837 | \$993.16 | \$0.00 | \$993.16 | 8 | N/A | \$943.50 | DISPUTED SERVICE: Allow reimbursement \$943.50 unless provider has already been reimbursed this amount. |

Copy to:

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[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
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