

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 11, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000796	Date of Injury:	05/09/2013
Claim Number:	[Redacted]	Application Received:	05/27/2014
Claims Administrator:	[Redacted]	Assignment Date:	07/14/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	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: 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,

[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

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:** 96101 Service denied; Provider seeking remuneration.
- Claims Administrator rational for denied service; “per CCI Edits, the value of this procedure is included in the value of the comprehensive Procedure.”
- Relevant CPT codes submitted with 96101: 99205 & 99354

CPT Code Definitions: **96101**, Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, mmpi, rorschach, wais), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report; **99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity, counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family; & **99354** Prolonged Services.

- CPT codes relevant to date of service resulted in two NCCI edits.
 - 1) 99205, Colum 1 Code; 96101 Colum 2 Code.
 - 2) 99354, Colum 1 Code; 96101 Colum 2 Code.

- Modifier -25, “significant, separately identifiable E/M service, above and beyond the usual pre and post-operative care associated with the procedure or service performed was,” not appended to submitted 99205, New Patient Level 5 service code.
- Modifier -59, “Distinct Procedural Service,” not appended to 96101
- Documentation provided does not indicate Modifier 25 is appended to CPT 99205.
- Documentation provided does not indicate Modifier 59 is appended to CPT 99354.
- IBR unable to correct or append codes previously submitted and signed (by Provider) on HCFA CMS1500 claim form for purposes of reimbursement.
- Claims Administrator denial of CPT 96101 was correct in accordance with 2014 Title 8, Article 5.3, Official Medical Fee Schedule § 9789.12.13, Correct Coding Initiative.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 96101 is not warranted.

Date of Service: 04/02/2014							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
96101	\$250.00	\$0.00	\$250.00	N/A	2	\$0.00	Refer to Analysis
99205	N/A	N/A	N/A	N/A	1	N/A	Service Not in Dispute
99354	N/A	N/A	N/A	NA	1	N/A	Service Not in Dispute

Copy to:

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

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]

