

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 22, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB14-0001951	Date of Injury:	04/08/2014
Claim Number:	[Redacted]	Application Received:	12/19/2014
Claims Administrator:	[Redacted]		
Assigned Date:	2/24/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	96101-59		

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 \$543.96 in additional reimbursement for a total of \$793.96. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$793.96 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,

Paul Manchester, MD, MPH  
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:
- 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 96101-59 x 6 units.
- Claims administrator denied code indicating on the Explanation of Review “Service/item included in the value of other services per CCI Edits. Related service could be on a separate bill.”
- Provider billed code 96101-59 along with 99205.
- Based on the NCCI edits code pair exist between CPT 99205 and 96101.
- Modifier Indicator column shows ‘1’ which states if a proper modifier is appended to the correct code and documentation supports the use of the procedure code then the edit may be overridden.
- Provider documents tests performed which included: MMPI-2 The Validity Scales, Bender Visual Motor Gestalt Test, Memory for Designs Test, Babcock Story Recall Test, Digit Span Subtest of the WAIS-IV and The Epworth Sleepiness Scale test.
- Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include:
  - Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
  - Global surgery modifiers: 24, 25, 57, 58, 78, 79
  - Other modifiers: 27, 59, 91
- A qualifying modifier was appended to the column 2 code CPT 96101 and therefore, reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 96101-59 is recommended.

<b>Date of Service:</b> 4/30/2014							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
96101-59	\$600.00	\$0.00	\$600.00	6	N/A	\$543.96	<b>DISPUTED SERVICE:</b> Allow reimbursement \$543.96

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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