

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 2, 2015

[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|------------------------|------------------------------|------------|
| IBR Case Number: | CB15-0000020 | Date of Injury: | 01/19/2012 |
| Claim Number: | [Redacted] | Application Received: | 01/09/2015 |
| Claims Administrator: | [Redacted] | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | WC003, 96101 and 96116 | | |

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,

Paul Manchester, MD

Chief Coding Reviewer

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
- National Correct Coding Initiatives
- Other: OMFS Physician's 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:** The denial of CPT 96101-93 and 96116-93; and report code WC003 for date of service 3/18/2014.
- Modifier 93: obsolete modifier for 2014 OMFS Physician Fee Schedule
- Provider billed 99245, 90899, 96101 x 9, and 96116 x 2; and was reimbursed \$312.00 for CPT 90899 and 2 units 96116. Provider appealed the initial reimbursement and re-billed WC003 in place of 90899.
- Documentation did not substantiate the reimbursement of 9 units of CPT 96101.
- Submitted authorization from the Claims Administrator, authorized a psychological evaluation only. Testing was not included in the authorization.
- CPT 96101 includes time spent as face-to-face time with the patient; interpreting and preparing the report.
- The start and end times were not documented for each test. Based on the documentation, it was not clear the time documented for each test was not overlapping time spent on other tests billed as 96101. Provider only noted the total minutes by each test/questionnaire on the super bill.
- Reimbursement is not recommended for CPT 96101.
- Provider was reimbursed 180.00 (minus a PPO reduction of 77.45) for two units of CPT 96116, no additional reimbursement recommended.
- WC003: Primary Treating Physician’s Permanent and Stationary Report
- The report submitted by the Provider was not identified as a Permanent and Stationary report, and did not meet the criteria of a separately reimbursable report.
- The Provider submitted an “Initial Psychological Evaluation Secondary Treating Physician’s Report Request for Authorization” report. This does not meet the criteria of a separately reimbursable report and the appropriate fee is included within the assessment and testing services performed the same day. Claims Administrator reimbursed provider \$132.00. No additional reimbursement due.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code WC003, 96101 and 96116.

| Date of Service: 3/18/2014 | | | | | | | |
|-----------------------------------|------------------------|---------------------|-----------------------|-----------------------|-------------------------|-----------------------------------|--|
| Physician Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Multiple Surgery | Workers’ Comp Allowed Amt. | Notes |
| 96101-93 | \$ 1650.00 | \$ 0.00 | \$ 1650.00 | N/A | N/A | \$0.00 | DISPUTED SERVICE: See Analysis. |
| 96116-93 | \$300.00 | \$180.00 | \$120.00 | N/A | N/A | \$180.00 | DISPUTED SERVICE: See Analysis. |

| | | | | | | | |
|-------|----------|----------|----------|-----|-----|--------|---|
| WC003 | \$220.00 | \$132.00 | \$220.00 | N/A | N/A | \$0.00 | DISPUTED SERVICE: See Analysis. Originally billed as 90899 and reimbursed \$132.00 |
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Copy to:

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