

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 13, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000102	Date of Injury:	03/14/2014
Claim Number:	[REDACTED]	Application Received:	01/23/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	2/19/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99205, WC0003 & 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: 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 \$195.00 for the review cost and \$65.81 in additional reimbursement for a total of \$260.81. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$260.81 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 reimbursement of code 99205 and denial of codes WC003 and 96101
- 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.
- 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 not appended to the column 2 code: CPT 96101. Reimbursement is not recommended for the billed code 96101.
- 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.

- Provider billed evaluation and management code 99205. The Claims Administrator down coded the E&M service to a 99202 on the initial EOR, reimbursed the Provider \$59.58 and applied a PPO discount of \$27.37
- The documentation did not substantiate the E&M code 99205. The evaluation and management services provided did not meet the three required components of CPT 99205: Comprehensive history and exam; and medical decision making of high complexity. However, documentation does meet the requirements of a 99203 and therefore reimbursement is warranted for 99203.
- Based on information reviewed, additional reimbursement is recommended for the evaluation and management code.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99203 is recommended.

Date of Service: 9/11/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
96101	\$1500.00	\$0.00	\$1500.00	9	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
WC003	\$220.00	\$0.00	\$220.00	29	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
99205 to a 99203	\$315.00	\$59.58	\$255.42	1	N/A	\$125.39	DISPUTED SERVICE: Allow reimbursement \$65.81

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.2	99205	96101	Allowed

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