

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000111	Date of Injury:	04/25/2013
Claim Number:	[REDACTED]	Application Received:	01/23/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	2/12/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	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, 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 codes 96101 and 96116
- Claims administrator denied codes indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day(96101, 99205)” and “In accordance with Clinical Based Coding Edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, Evaluation and Management services procedure (90000-99999) has been disallowed”
- Provider billed codes 96101 and 96116 along with 99205
- Based on the NCCI edits code pair exist between CPT 99205 and 96101 and 96116.
- 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 codes: CPT 96101 or 96116. Reimbursement is not recommended for the billed codes 96101 or 96116.

