

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 WC007-30 and 96101-59, 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.
- Claims Administrator denied WC007-30 with rationale "This report does not fall under the guidelines for a separately reimbursable report found in the General Instructions Section of the Physician's Fee Schedule"
- Modifier -30 states: Consultation reports requested by the Qualified Medical Evaluator ("QME") or Agreed Medical Evaluator ("AME") in the context of a medical-legal evaluation. Use WC007, modifier -30.
- A request for Provider to submit a report was not identified in this review. Therefore, reimbursement of WC007 is not warranted.
- Claims Administrator denied 96101 with rationale "Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure"
- Provider billed code 96101 with modifier -59 which is an approved modifier to append to the column '2' code.
- Psychological Testing Report submitted documents 9.5 hours of time involved for application, scoring and interpretation.

- Based on information reviewed and guidelines, reimbursement of 96101 is warranted.

The table below describes the pertinent claim line information.

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

| Date of Service: 01/27/2015 | | | | | | |
|------------------------------------|------------------------|---------------------|-----------------------|--------------|-----------------------------------|---|
| Physician Services | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes |
| 96101-59 | \$999.02 | \$0.00 | \$999.02 | 9.5 | \$815.94 | DISPUTED SERVICE: Allow reimbursement \$815.94 |

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