

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 8, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0002102	Date of Injury:	07/26/2011
Claim Number:	[Redacted]	Application Received:	11/09/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	06/24/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	90792		

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 \$166.08 in additional reimbursement for a total of \$361.08. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$361.08 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: 5% PPO Discount
- National Correct Coding Initiatives
- Other: CPT Assistant Psychiatry

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 seeking remuneration for 90792, Psychiatric diagnostic evaluation with medical services for date of service 06/24/2015
- Claims Administrator denied code indicating “The charge was denied as the report/documentation does not indicate that the service was performed”
- Beginning in 2013, there are two new codes to use to report psychiatric diagnostic procedures: 90791 for evaluations that do not include medical services, and code 90792 for evaluations that do include medical services. "Medical services" consist of medical activities or consideration, such as performing additional elements of the physical examination, considering writing a prescription, ordering laboratory or imaging examination(s), and considering modifying psychiatric treatment based on medical comorbidities.
- Documentation submitted for review supports billed code 90792.
- Reimbursement of 90792 is warranted.
- PPO contract not submitted for review.
- EOR received reflects a 5% PPO discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 90792

Date of Service: 06/24/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
90792	\$202.83	\$0.00	\$202.83	1	\$166.08	\$166.08 Due to Provider

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