

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 8, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-002258	Date of Injury:	10/02/2008
Claim Number:	[Redacted]	Application Received:	12/10/2015
Assignment Date:	02/05/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	02/05/2015 – 02/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	90880		

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, M.D., M.P.H.
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
- Medicare Billing Manual
- NCCI Edits
- AMA CPT
- OMFS

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 additional remuneration for 90880 for dates of service 02/05/2015, 02/12/2015, & 02/19/2015.**
- The Claims Administrator's reimbursement rationale indicates the following: "Provide the correct CPT codes for all svcs rendered."
- CMS 1500 form indicates the following: 90880-**93-59-25** and WC008 Report Code.
- **Modifier -93**, unless otherwise agreed upon between the Provider and the Claims Administrator, Interpreter Services are included in the value of the service performed.
 - Modifier -93 Definition: Interpreter Required
- **Modifier -59**- not relevant to services reflected on the CMS 1500
 - Modifier - 59 Definition: "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. **Documentation must support a different session**, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25" (AMA CPT)
- **Modifier - 25** not relevant to services reflected on the CMS 1500.
 - Modifier 25 Definition: significant, separately identifiable **evaluation and management [E/M] service** by the same physician on the same day of the procedure or other service).
- Documentation includes a signed attestation by the Injured Worker that **three services** were performed: 90853, 90880, & 90901 **for each date of service.**
- This signed and dated documentation by the Injured Worker **does not indicate that the requirements for 90880 were fulfilled in accordance with the code description defined in the American Medical Association Current Procedural Terminology Code Book.**
- Attestation indicates other services performed. Since Modifier 59 and 25 were submitted on the CMS 1500 and are not relevant to the billed service this suggests that other services were also submitted.
- Signed Attestation also indicates the following: "Procedure codes 90880 and 90853 were provided on the same day but not in conjunction during the same session." All services performed must be submitted in order to abstract the necessary requirements for reimbursement. One such requirement is the session **report** for each date of service relating to 90880; documentation must support the level of service reported.
- If 90880 was the only service performed or billed for dates of service 02/05/2015, 02/12/2015, & 02/19/2015, then Modifier 59 & 25 were not warranted as these suggest other services were also reported (billed) by the Provider on 02/05/2015, 02/12/2015, & 02/19/2015.
- Without documentation to provide a clear picture of the services performed on 02/05/2015, 02/12/2015, & 02/19/2015, IBR is unable to determine the correct reimbursement.

- **Article 5.5.0. Rules § 9792.5.7.** Requesting Independent Bill Review (b)(2) **The proper selection of an analogous code or formula based** on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- CPT 99080 Definition: **Hypnotherapy**
- Authorization dated 02/19/2015 indicates “12 units of **Group Psychotherapy**,” for “depressive order.+
- **Authorization for Group Therapy (90853) does not support billed service 99080 Hypnotherapy.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the documentation submitted, additional reimbursement for 90880 services is not indicated.

Date of Service: 02/05/2015, 02/12/2015, & 02/19/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
90880	\$192.50	\$0.00	\$192.50	1	\$0.00	Refer to Analysis
90880	\$192.50	\$0.00	\$192.50	1	\$0.00	Refer to Analysis
90880	\$192.50	\$0.00	\$192.50	1	\$0.00	Refer to Analysis
90853	N/A	N/A	N/A	-	N/A	Service Not In Dispute
90901	N/A	N/A	N/A	-	N/A	Service Not In Dispute

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