

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 21, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002331	Date of Injury:	09/07/2010
Claim Number:	[REDACTED]	Application Received:	12/28/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	90836 and 96101-59 x 5		

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
- Other:

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 of codes 90836 and 96101-59 x 5 performed on date of service 07/23/2015.
- Provider was requested to perform a psychological evaluation on the injured worker as a secondary physician.
- Claims Administrator denied codes indicating “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- Provider billed codes 90836 and 96101-59 along with 99215-25 and WC002.
- Authorization letter from Utilization Review to Primary Treating Physician dated 07/01/2015 documents services requested: “Type: Office Visit; Description: Psychiatric Consult” and “Determination: Certified”
- Utilization Review did not authorize psychological testing. Therefore, reimbursement of 96101 is not warranted.
- 90836: Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
- Provider’s Assessment report submitted did not document face to face time spent with the injured worker.
- Without time documented, reimbursement of 90836 is not warranted.

