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## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 17, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000101	Date of Injury:	04/23/2012
Claim Number:	[REDACTED]	Application Received:	01/22/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/02/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99215-25, WC002, and 90836		

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 \$54.59 in additional reimbursement for a total of \$249.59. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$249.59 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: N/A
- 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 seeking remuneration of codes 99215-25, WC002, and 90836 performed on 10/02/2015.
- Claims Administrator denied codes indicating “Service not authorized during the Utilization Review process”
- Authorization dated May 14, 2015 includes description, duration and frequency as “Outpatient Cognitive Bio-Behavioral Therapy twelve (12) sessions.” Authorization does not document specific codes to be billed.
- Provider is not the Primary Treating Physician. WC002 only applies to the Primary Treating Physician, the Provider is considered a Secondary Treating Physician.
- Reimbursement of WC002 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).
- Documentation does not support psychotherapy service or time spent with the patient.
- Reimbursement of 90836 is not warranted.
- 99215 is the highest level Evaluation and Management code which includes two or three key components: comprehensive history, comprehensive examination and medical decision making of high complexity.

- Report submitted does not document services of a 99215 performed on 10/23/2015 but as a 99212.
- Opportunity for Claims Administrator to Dispute Eligibility sent on 1/25/2016. A response from Claims Administrator was not received for this review.
- Reimbursement of 99212 is warranted based on documentation submitted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 99212 is recommended.

<b>Date of Service:</b> 10/02/2015						
<b>Provider Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99212	\$615.00	\$0.00	\$263.45	1	\$54.59	\$54.59 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]