

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 17, 2014

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001025	<b>Date of Injury:</b>	02/14/2008
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	07/18/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	09/04/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	ML104-94		

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 \$250.00 for the review cost and \$10687.50 in additional reimbursement for a total of \$10937.50. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$10937.50 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,

[Redacted]  
[Redacted]

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: Medical Legal Expenses

## 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 ML 104-94. Provider states “At the request of the Claims Adjuster we performed a PQME. Extensive additional records were provided by both parties along with an appointment to re-evaluate the applicant. A 236 page report was submitted and not paid for. The Claims Examiner stated via 3/6/14 notice she would make a partial payment. This NEVER happened. The Claims Examiner did not send the EOR with her note. The Claims Examiner was notified we never received the check via SBR and she ignored this. The doctor is entitled to be paid for the hours he spent performing this very difficult evaluation. PQME’s do not require pre-authorization.”
- Claims Administrator shows an allowance of \$9125.00 on the Explanation of Review dated 6/17/2014 for ML 104 indicating “Recommended payment of this procedure or supply should be reimbursed only if pre-authorization has been obtained by the Claims Examiner.” An allowance of \$543.96 for CPT 96101 Provider had billed was also shown on the same Explanation of Review with explanation “There was no UR procedure/treatment request received.” A copy of the check for \$543.96 was received by Claims Examiner.
- Based on review of the report submitted, the complexity of the report was analyzed and compared to Complexity Factors 1-10. Complexity Factors 4, 6, 7 and 9 were met. ML 104 criteria met: four or more complexity factors.

- Complexity factor #4: Criteria Met: 1 & 2 = 42.75 hours in combination of two complexity factors 1- 3. Complexity factor 6: Addressing this issue of Causation, Criteria met. Beginning on page 233 of the Medical Legal Report. Complexity Factor #7: Addressing the issue of Apportionment, Criteria Met Refer to Pages 234 – 235 of the Medical Legal Report. Complexity factor #9: A psychiatric or psychological evaluation, Criteria Met Refer to Page 13 of the Medical Legal Report. Separate CPT Code billed in addition to Criteria 9.
- Provider billed with a modifier -94 = Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. No evidence of a request for an Agreed Medical Evaluator as described in (3) of ML 104 has been submitted and therefore no additional increase of 1.25 can be reimbursed.
- Provider documents time spent: Preparation of written report: 29 hours, however, report preparation is not a complexity factor to be reimbursed and therefore is not included in the total units; face to face time 3 hours (12 units); and reviewing medical records 39.75 hours (159 units) = 171 units.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 1/13/2014						
Medical Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML 104	\$23019.90	\$0.00	\$22475.94	171	\$10,687.50	<b>DISPUTED SERVICE:</b> Allow reimbursement \$10,687.50

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