

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 22, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001396	Date of Injury:	07/29/2014
Claim Number:	[Redacted]	Application Received:	08/20/2015
Assignment Date:	09/08/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	04/27/2015 – 04/27/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	96101		

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 \$210.79 in additional reimbursement for a total of \$405.79. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$405.79** 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, 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
- Official Medical Fee Schedule
- National Correct Coding Initiatives
- Official Medical Legal Fee Schedule

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 full remuneration for 96101 services performed on 04/27/2015.**
- The Claims Administrator's based reimbursement on the following rationale: "applicable fee schedule."
- Med-Legal services not in dispute; units of 96100 is disputed by the Claims Administrator; EOR reflects 5 of 7 submitted units reimbursed.
- **§ 9794 Reimbursement of Medical-Legal Expenses.**
 - (a) The cost of comprehensive, follow-up and supplemental medical-legal evaluation reports, diagnostic tests, and medical-legal testimony, regardless of whether incurred on behalf of the employee or claims administrator, shall be billed and reimbursed as follows:
 - (1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the official medical fee schedule adopted pursuant to Labor Code Section 5307.1. In no event shall the claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report.

Additionally, the claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the claims administrator, if adequate medical information is already in the medical record provided to the physician.

- Psychological Report, Page 17, the following time factors associated with each psychological exam are noted:
 - MMPI-2 = 1.5 hours
 - MCMI-III = 1.5 hours
 - Sentence Completion Test = .5 hours
 - Whaler Physical Symptom Inventory = .5 hours
 - Beck Depression Scale = 1 hr
 - Beck Anxiety Scale = 1 hr
 - Work Function Impairment Form Questionnaire = 1 hr
 - Total Hours = 7
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 96101 pursuant to § 9794.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 96101.

Date of Service: 04/27/2015						
Physician Services Med-Legal Fee Schedule.						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
96101	\$966.14	\$453.30	\$512.84	7	\$664.09	OMFS Allowable x 7 hours (-) Reimbursed Amount = \$210.79 Due Provider.

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