

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 12, 2015

[Redacted]

IBR Case Number:	CB15-0000444	Date of Injury:	12/01/2011
Claim Number:	[Redacted]	Application Received:	03/26/2015
Claims Administrator:	[Redacted]		
Date Assigned:	4/15/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-94 and 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 \$7178.23 in additional reimbursement for a total of \$7373.23 .A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$7373.23 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:
- National Correct Coding Initiatives
- Other: §9795 Reasonable Level of Fees for 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 reimbursement of ML 104-94 and non-payment of 96101
- Claims Administrator reimbursed ML 104-94 in the amount of \$468.75 with no comment or notes regarding the reduction in payment. Claims Administrator did not document CPT 96101 on the first EOR but did on the second EOR indicating zero payment stating “Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim”
- Invoice from Provider received billed code ML 104-94, Represented Qualified Medical Evaluation – Psychiatry; and 96101, Psychological Testing used in a Medical Legal setting (billed at \$125 per hour).
- ML104-Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following: (1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and

concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon. (2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician; (3) A comprehensive medical - legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face – to - face time with the injured worker, preparing the report and, if applicable, any other activities.

- Provider’s report documents “Reviewing records: 18.50 hours; B) face-to-face: 1.50 hours; C) preparation of the written report: 9.50 hours; D) time for scoring, review and interpretation of psychological testing: 3.00 hours. Total time spent on this case: 32.50 hours. As provider was requested to perform a QME and documented requested information, additional reimbursement is warranted for ML 104.
- 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.
- Provider was requested to perform as a Qualified Medical Evaluator, not Agreed Medical Evaluator and therefore, the additional increase of 1.25 is not warranted.
- Provider documents psychological tests performed in order to make a sound decision and therefore reimbursement of 96101 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes ML 104 and 96101 is recommended

Date of Service: 8/14/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 104	\$9218.75	\$468.75	\$8750.00	118	N/A	\$7375.00	DISPUTED SERVICE: Allow reimbursement \$6906.25
96101	\$375.00	\$0.00	\$375.00	3	N/A	\$271.98	DISPUTED SERVICE: Allow reimbursement \$271.98

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