

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 1, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000525	Date of Injury:	10/09/2010
Claim Number:	[REDACTED]	Application Received:	04/01/2014
Claims Administrator:	[REDACTED]	Assignment Date:	06/26/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-94 and 96100		

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 \$24,215.84 in additional reimbursement for a total of \$24,465.84 .A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$24,465.84 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]

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
- AMA CPT 1997
- Other: 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 disputing \$0.00 reimbursement of code Med-Legal Services, ML104 94 and 96100 performed on dates of service 11/26/2013
- The Provider is a Qualified Medical Examiner who agreed to conduct a medical legal evaluation on an injured worker. Submitted charges from the Provider included a ML104 -94 evaluations and CPT Code 96100; billed to the Claims Administrator for a total of \$24,670.36.
- The Claims Administrator states the claim is “non-compensable” as “services were not authorized.”
- Abstracted information from the supplied documentation reveals an **Authorization for Med-Legal services** in the form of a letter. The letter is dated November 25, 2013 and it appears to be from two attorneys; One representing the Applicant and the Other Representing the Claims Administrator.
- The Authorization asks the Provider to act in the capacity of a “Panel Qualified Medical Evaluator” and to provide a psychiatric evaluation on an Injured Worker.
- Provider is an M.D. specializing in Psychiatry.
- Authorization indicates “Adjudication of Claim, DWC-1 Claim Form, deposition transcripts, and the entire medical file to date,” were sent to the Provider for review.

- Authorization requests the Provider to render a Medical Opinion relative to Psychiatry and address the following: 1) Industrial related psychiatric injury as claimed. 2) If “temporary or totally disabled on an industrial basis” and to indicate “all reasonable periods of such disability.” 3) Permanent impairment relative to AMA guidelines and “when injury became permanent and stationary” and when did the “applicant, become permanent and stationary.” 4) GAF and “all other appropriate sections of the AMA to indicate to parties which method to determine the applicants impairment if any.” 5) Address industrial medical conditions affecting applicant’s “daily living and activities.” 6) Future medical treatment and recommendations. 7) Apportionment. 8) If applicant “self-procured” medical treatment 9) Applicant’s ability to return to “usual and customary work duties,” and “indicate the applicant’s residual functional capacities.” 10) Detailed “interim” history from applicant regarding: activities since injury, new employment, self-employment, new injuries or legal actions.”
- Provided Medical Evaluation documentation presented for IBR includes a 193 page evaluation.
- **OMFS Med-Legal Definition ML104:** *Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances* requires 4 complexity factors.
- Abstracted information from QME report indicates complexity factors, including requested Causation and Apportionment have been met for ML104.
- **OMFS Med-Legal Definition Modifier -94:** Agreed Medical Examiner, + 1.25 multiplier.
 - Authorization reflects agreement between the defense and applicant’s attorneys to perform medical/legal evaluations in a workers’ compensation case.
 - Injured Worker is represented by a Legal Party noted on Authorization.
- Provider’s time is documented and attestation on QME report was signed by Provider on 12/18/2013. Time stated on provided report for ML104 is as follows:
 - Face-to- Fact time: 3.5 hours
 - Review of Records: 45.75 hours
 - Report Preparation: 26.5 hours
 - Total Units: 303
 - Total ML104 Units reflected on CMS 1500 form: 303
- **CPT 96100:** Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, eg, wais-r, rorschach, mmpi) with interpretation and report, per hour.
- Authorization requests Psychological Testing.
- Provider administered and reported on the following Psychological Tests: 1) MMPI-2: 3.5 hours 2) MCMI 1.5 hours 3) Million Behavior Medicine Diagnostic Interpretative Report 1.5 hours. 4) Beck Depression and Anxiety Inventory: .5 hours.
 - Total Hours 6
 - Total Hours reflected on CMS 1500 form: 6

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement of code ML104 94 and 96100 are warranted in the amount listed below.

Date of Service: 11/26/2013						
[REDACTED]						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$23,670.36	\$0.00	\$23,670.36	303	\$18,937.50	DISPUTED SERVICE: Allow additional reimbursement of \$18,937.50
Modifier - 94	-	\$0.00	-	-	\$4,734.38	DISPUTED SERVICE: Allow additional reimbursement of \$4,734.38
96100	\$599.45	\$0.00	\$599.45	6	\$543.96	DISPUTED SERVICE: Allow additional reimbursement of \$4,734.38

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
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