

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 12, 2014

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

<b>IBR Case Number:</b>	CB14-0000716	<b>Date of Injury:</b>	9/28/2012
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	5/12/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	7/23/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	ML104-95, 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 \$250.00 for the review cost and \$4000.00 in additional reimbursement for a total of \$4250.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$4250.00 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 4620.6(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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: 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 is dissatisfied with denial of ML 104-95 and 96101.
- Claims Administrator denied codes and indicated on the Explanation of Review “No allowance has been recommended for this procedure/service/supply. Please see special \*note\* below: This charge was adjusted for the reasons set forth in the attached letter.” Letter attached states “This medical-legal evaluation was not authorized.”
- Documentation submitted for this review included a letter from the attorney requesting Provider as a Panel Qualified Medical Examiner also “We request that you provide a thorough report which should initially include a history of the injury and a review of the records as well as the applicant’s current symptoms and complaints and your diagnoses.”
- Pursuant §9793 (h) “Medical-legal expense” means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist: (1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code. (2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving

or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.

- §9795 ML 104 - 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.
- -95 Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.
- 96101 - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report. A separate report was not submitted for 96101 and therefore the testing is included with the ML 104 total units.
- Provider documented 4 hours of face-to-face history & Psychiatric interview; 4 hours of administration, scoring, interpretation and synthesis of these results; 8 hours preparation of the report and integration of all additional data for a total of 16 hours. A request for the Qualified Medical Examiner was evident and denial of ML 104-95 and 96101 by Claims Administrator was not correct. The requirements of ML 104-95 (64 units) were met and warrant reimbursement.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code ML 104-95 and 96101 are warranted.**

<b>Date of Service: 1/16/2014</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 104-95	\$4250.00	\$0.00	\$4250.00	64	N/A	\$4000.00	<b>Disputed Service: Allow reimbursement \$4000.00</b>

Copy to:

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[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
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