

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 26, 2015



IBR Case Number:	CB14-0001920	Date of Injury:	08/19/2013
Claim Number:	[REDACTED]	Application Received:	12/12/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-94, 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.

IBR Case Assigned: 1/21/2015

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 \$5,584.48 in additional reimbursement for a total of \$5,834.48 A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$5,834.48 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

MAXIMUS FEDERAL SERVICES, INC.

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Chief Coding Reviewer

cc:



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
- Other: Medical-Legal Fee Schedule and OMFS Physician 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 disputing the denial of Medical Legal Code ML104-94 and 96101 x 3.
- The supplied medical record, provided documentation and support for ML104-94 and 96101 x 3.
- ML104: An evaluation which requires four or more of the complexity factors listed under ML 103.
- Provider documented a total of 20 hours spent on ML evaluation & report: 3 hours face-to-face time; 3 hours record review; 11 hours producing report, analysis and medical research; and 3 hours of psychological testing billed as 96101.
- In a separate section at the beginning of the report, the Provider specified which four or more of the complexity factors were satisfied for the ML104 evaluation:
 - “Greater than 6 hours spent on any combination of three complexity factors (1-3), 2+ hours face to face, or 2+ hours record review, or 2+ hours of medical research.”
 - “Causation Addressed”
 - “Apportionment Addressed”
 - “Psychiatric evaluation is primary focus of evaluation”
- It was found that the medical record demonstrated the following **four** complexity factors:
 - Four or more hours spent on any combination of two complexity factors (1)-(3), which shall count as two complexity factors (**1st & 2nd complexity factors**)
 - Addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation (**3rd complexity factor**)
 - (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. (**4th complexity factor**)
- The documentation included a Claims Administrator request for a QME exam to be performed by the Provider, and a request for determination of causation.
- The submitted QME appointment Notification Form, indicated an appointment for the injured worker with the Provider, date of appointment 3/7/2014.
- Additional reimbursement recommended for ML104 x 68 units (17hours) and CPT 96101 x 3 units.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code: ML104-94 and 96101.

Date of Service 3/7/2014							
Medical-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp	Notes

						Allowed Amt.	
ML104-94	\$ 5312.50	\$ 0.00	\$ 5312.50	68	N/A	\$ 5312.50	DISPUTED SERVICE: Additional reimbursement warranted in the amount of \$5312.50
96101	\$375.00	\$0.00	\$375.00	3		\$271.98	DISPUTED SERVICE: Additional reimbursement warranted in the amount of \$271.98.

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