

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 2, 2015

██████████
██████████
██████████

IBR Case Number:	CB15-0001295	Date of Injury:	09/22/2014
Claim Number:	██████████	Application Received:	08/07/2015
Assignment Date	August 28, 2015		
Claims Administrator:	██		
Date(s) of service:	03/05/2015 – 03/05/2015		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	ML104-86-92		

Dear ██████████

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 \$758.91 in additional reimbursement for a total of \$953.91. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$953.91** 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: ██████████
██

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
- OMFS

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 remuneration for ML104-86-92 services performed on 03/05/2015.
- The Claims Administrator based reimbursement on “better defining service,” 99215 Established Patient Evaluation.
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- **RFA DLSR 5021 form** reflects authorized service signed by the Claims Administrator on 02/13/2015. For the following services:
 - **Psych Re-evaluation ML104, 4 – 6 hours**
 - **Psych Testing 96101, 5 – 6 hours**
 - **RFA does not indicate specific issues to be addressed in the ML104 evaluation.**
- **Complex Psychological Re-evaluation Documentation, beginning on page 4 of the report, compared to ML104 Med-Legal OMFS “4 or more complexity factor” requirement:**
 - (1) 2 or more hours Face-to-Face time – **Criteria Met**, Provider States – “2.0 hours”
 - (2) 2 or more hours Record Review – **Criteria Not Met**. Provider states “no medical records available for my review.”
 - (3) Two or more hours of medical research by the physician; Med. Legal OMFS, “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” **Criteria Not Met** – in accordance with §9793 (j): "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.” Provider states “15 min.”
 - (4) “**Four or more hours** spent on any combination **of two** of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), **or** (3) used to make this combination shall not also be used as the third required complexity factor.” **Criteria Not Met**
 - (5) “Six or more hours spent on any combination **of three** complexity factors (1)-(3), which shall count as three complexity factors.” **Criteria Not Met**
 - (6) Causation – “**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.” **Criteria Not Met – RFA does not indicate causation requested.**
 - (7) Apportionment – **Criteria Met**
 - (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances; **Criteria Not Met.**

- (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Met**
- (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. Date of QME 07/26/2014. **Criteria Not Met,**
- **3 Complexity factors** abstracted from Complex Psychological Re-evaluation Documentation.
- **Med-Legal services were authorized.** As such, a California Specific Med-Legal Evaluation Code, opposed to a HCPCS evaluation and management code, such as re-assigned code 99215, would be a better defining service.
- **ML103 Complex Comprehensive Medical-Legal Evaluation.** Includes evaluations which require three of the complexity factors Paid at a flat rate. All expenses are included except for diagnostic testing.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for ML104; reimbursement is recommended for documented service ML103.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104-86-92

Date of Service: 03/05/2015 Physical Medicine						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML104 – 86-92	\$1,562.50	\$178.59	\$1,383.91	1	\$937.50	\$758.91 Due Provider Refer to Analysis

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