

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 4, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001836	Date of Injury:	11/16/2009
Claim Number:	[REDACTED]	Application Received:	10/06/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/06/2015 – 07/06/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-95		

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 \$2,187.50 in additional reimbursement for a total of \$2,382.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$2,382.50** 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: [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
- Med-Legal 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 ML104-95 services performed on 07/06/2015.**
- The Claims Administrator reimbursed the Provider “\$1,625.00” of “\$3,812.50,” indicating “Official Medical Fee Schedule” rational.
- EOR’s do not indicate ML104 level of services down-coded or denied.
- Since EOR’s refer to OMFS as reason for reimbursement, the Med-Legal Fee Schedule will be utilized for this review.
- Authorization for services not submitted for IBR. However, the Claims Administrators reimbursement and non-communicative response to IBR’s Opportunity to Dispute of 10/09/2015 indicates acceptance for ML104 Extraordinary Circumstances service. This Bill Review will analyze the submitted documentation for the necessary elements required for ML104 services.
- Abstracted data from QME report for date of service 07/06/2015, and submitted documentation, does not support the ML104 Criteria for “Causation” as this element requires a specific request from the Claims Administrator and/or Legal Parties.
- The following ML104 Criteria has been met:
 - ✓ Face – to – Face Time: Provider indicates “3 hours.”
 - ✓ Record Review: The Provider indicates “3 hours.”
 - ✓ Apportionment: Page 11 of the QME report indicates previous “deferred” status. Page 38 of said report reflects full percentage of Apportionment addressed for date of service 07/06/2015.
 - ✓ A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
- 4 complexity factors abstracted from submitted QME report; Criteria Met for ML104 Services.
- Break Down of time as reported on page 1 of the QME report:
 - 3 hours Face-to-Face
 - 3 hours record review
 - 9.25 hours report preparation
 - Total Hours = 15.25
 - Total Units = 61
- ❖ Noted: Provider **separately** indicates “5.5 hours” spent on “administration, scoring, and interpretation” of psychological testing. This language indicates the ‘5.5 hours’ were not included in the overall time spent preparing the 48 page QME report. The Total 15.25 Hours indicated for ML104 services does not include the stated 5.5 hours.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for ML104 services.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 07/06/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$3,812.50	\$1,625.00	\$2,187.50	61	\$3,812.50	Med-Legal OMFS (-) Reimbursed Amount = \$2,187.50 Due Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]