
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 13, 2015

██████████
██████████
██████████

IBR Case Number:	CB15-0001910	Date of Injury:	03/03/2015
Claim Number:	██████████	Application Received:	10/15/2015
Claims Administrator:	████████████████████		
Date(s) of service:	03/18/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	ML103-86		

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 \$722.68 in additional reimbursement for a total of \$917.68. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$917.68 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, MPH
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
- Official Medical Fee Schedule
- National Correct Coding Initiatives

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 seeking remuneration for ML 103 on date of service 03/18/2015.
- Claims Administrator reimbursed ML 103 as 99205 indicating on the Explanation of Review “The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the documentation submitted with the billing”
- Claims Administrator’s Authorization to Provide Treatment approved “Provider evaluation for AOE/COE”
- 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.
- Page 3 of Provider’s report documents “The following complexity factors apply: 1. Addressing the issue of medical causation. 2. Addressing the issue of apportionment. 3. 2.0 hours of face-to-face time with the patient. 4. 0.25 hours of medical record review. 5. Psychological Evaluation as the primary focus.”
- Complexity factors for ML 103 met from Complex Psychological Evaluation include (1) 2 or more hours face-to-face, (6) Causation and (9) A psychiatric or psychological evaluation.
- Based on aforementioned documentation and guidelines, reimbursement of ML 103 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 103

Date of Service: 03/18/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML 103	\$937.50	\$214.82	\$722.68	1	\$937.50	\$722.68 due to Provider

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