

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 10, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000359	Date of Injury:	05/01/2012
Claim Number:	[REDACTED]	Application Received:	03/12/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	4/10/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML101-93		

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 \$687.50 in additional reimbursement for a total of \$882.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$882.50 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, MD, MPH
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: Reasonable Level of Fees for Medical – Legal Expenses

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 reimbursement of ML 101-93, Follow-up Medical Legal Evaluation.
- Claims Administrator down coded ML 101 to ML 102 indicating on the Explanation of Review “reimbursement of code ML 101 is not recommended as the evaluation does not qualify as a follow-up medical legal”
- Letter from attorney dated 12/1/2014 states “Thank you for agreeing to continue to act as the psychiatric Panel Qualified Medical Examiner in the above-entitled case and perform a reevaluation of the Applicant.”
- On page 4 of the Provider’s report it states that he previously evaluated the patient on April 10, 2014. As this date of service is 12/2/2014, the evaluation falls within the 9 months to qualify as a re-evaluation.
- ML 101 - *Follow-up Medical-Legal Evaluation*. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour

- Page 11 of the Provider’s report documents face-to-face time with patient as 1.25 hours; Reviewing of records as 1.00 hours; Preparing the report as 3.00 hours for a total of 5.25 hours.
- Based on information reviewed, additional reimbursement of ML 101 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 101 is recommended.

Date of Service: 12/2/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
ML 101	\$1312.50	\$625.00	\$687.50	21	N/A	\$1312.50	DISPUTED SERVICE: Allow reimbursement \$687.50

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