

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 3, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000037	Date of Injury:	10/23/2014
Claim Number:	[Redacted]	Application Received:	01/08/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	10/01/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-94		

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 \$390.63 in additional reimbursement for a total of \$585.63. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$585.63 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
- 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 seeking remuneration of ML 104-94 performed on date of service 10/01/2015.
- Claims Administrator down coded ML 104 to ML 103 indicating "the following are not considered factors or were not met: Record Review, Causation, Apportionment"
- Request for Agreed Medical Evaluator was not submitted for review.
- Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:
 - (1) 2 or more hours Face-to-Face time: **Criteria Met** 2.5 hours of face-to-face time
 - (2) 2 or more hours Record Review: **Criteria Not Met** .5 hours of Record Review
 - (3) Two or more hours of medical research by the physician; **Criteria Not Met**
 - (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.
 - (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 Met on page 2 of Provider’s Addendum report.**

- (7) Apportionment – **Criteria Not 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. **Criteria Not Met**
- **Three (3) Complexity Factors Abstracted From AME Report**
- Modifier -94: Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25.
- Opportunity for Claims Administrator to Dispute Eligibility letter sent on 1/11/2016. A response was not received for review.
- Based on documentation reviewed, additional reimbursement for ML 104-94 is not warranted. Additional reimbursement for ML 103-94 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 103-94

Date of Service: 10/01/2015						
Medical Legal						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
ML103-94	\$3164.07	\$781.25	\$1328.13	27	\$1171.88	\$390.63 Due to Provider

Copy to:

[REDACTED]

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