

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 20, 2015



IBR Case Number:	CB14-0001901	Date of Injury:	10/14/2011
Claim Number:	[REDACTED]	Application Received:	12/09/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104		

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.

IBR Case Assigned: 1/20/2015

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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

Chief Coding Reviewer

cc: [REDACTED]

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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
- Other: Med-Legal Fee Schedule

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 disputing the reimbursement of ML104 performed on date of service 6/16/2014
- Claims Administrator reviewed and reimbursed the billed Med-Legal code ML104 as 99215.
- Provider indicated at the beginning of the submitted report the following ML104 complexity factors were met:
 - Causation
 - Apportionment
 - Psychological evaluation which is the primary focus of the Med-legal evaluation
 - Addressing the issue of denial or modification or treatment by the claims administrator following utilization review under Labor Code section 4610.
- In reviewing the submitted medical report, Authorization regarding ML104 services could not be found during this IBR. Med-Legal services require authorization as per Section 9793, Definitions (g) Medical-legal expense:
 - (2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.
- Issue of denied or modified treatment was not apparent. Request for the Medical-Legal report was submitted as part of the documentation.
- The documentation did not satisfy the requirements of Complexity factors: Causation or Apportionment. The following criteria was not satisfied:
 - (6) 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;
 - (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the *Table of Contents of Guides to the Evaluation of Permanent Impairment* (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
- Reimbursement is not recommended for ML104, based on the submitted documentation. Medical-Legal ML104 reporting requirements were not met, or appear to be requested by another party.
- Provider was reimbursed the OMFS allowance for 99215, minus a PPO discount of \$35.15.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML104.

Date of Service: 6/16/2014							
Medical-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML104 (99215)	\$ 2875.00	\$ 132.00	\$ 2743.00	46	N/A	\$132.00	DISPUTED SERVICE: See Analysis.

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