

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 26, 2016

[Redacted]

IBR Case Number:	CB16-0000169	Date of Injury:	01/28/2011
Claim Number:	[Redacted]	Application Received:	02/04/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	11/25/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104 and 96101		

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: 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, M.D., M.P.H.
Medical Director

Cc: [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
- Provider's Response to Claims Administrator IBR Response
- 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 additional remuneration for ML104 and 96101 services performed on 11/25/2014.**
- **The Claims Administrator indicates** ML104 reimbursed as ML103.
 - EOR reflects "ML103" reimbursed based on the documentation submitted.
- Request for QME services received for IBR.
- **QME Examination Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:**
 - (1) 2 or more hours Face-to-Face time – **"1.5 hours."**
 - (2) 2 or more hours Record Review – **"25.5 hours."**
 - (3) Two or more hours of medical research by the physician;
 - Med. Legal OMFS, "An evaluator who specifies complexity factor (3) **must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon**" **Criteria Not Met as time not indicated.**
 - (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 Met**
 - (5) "Six or more hours spent on any combination **of three** complexity factors (1)-(3), which shall count as three complexity factors." **Criteria Not Met**

- (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 Not Met**
- (7) Apportionment – Not documented, **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 Applicable**
- **Three (3) Complexity Factors Abstracted From QME Report.**
- Criteria not met for ML104.
- **ML103 –**
 - **A basic medical evaluation which involves three complexity factors.**
 - Paid at a flat rate.
 - **All expenses are included** except for diagnostic testing.
- Provider billed 96101: Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), **per hour** of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
- Provider documents “time for scoring, review, and interpretation of psychological testing: 3.00 hours”
- Provider was reimbursed \$271.98 for the 3 units of 96101.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for ML104 or 96101.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104 and 96101

Date of Service: 11/25/2014 Med-Legal						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML103	\$11,406.25	\$937.50	\$10,468.75	1	\$937.50	Refer to Analysis
96101	\$375.00	\$271.98	\$103.02	3	\$271.98	Refer to Analysis

[REDACTED]

[REDACTED]