

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 24, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB13-0000614	Date of Injury:	1/23/2013
Claim Number:	[Redacted]	Application Received:	10/17/2013
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: 06/23/2014

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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

[Redacted]
[Redacted]

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
- National Correct Coding Initiatives
- Other: MED LEGAL 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 disputing reimbursement for ML104-95. Claims Administrator Reimbursed \$937.50, Provider submitted \$2,437.50. Provider is seeking full remuneration for services rendered.**
- The Claims Administrator down-coded the billed ML104-95 to ML103 with the following explanation: “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.”
- The Provider, an Orthopedic Surgeon, was requested by Legal Parties in the matter of (Injured Worker) v. (Employer/Claims Administrator) to perform a medical evaluation and render a medical opinion on the Injured Worker. The request is dated May 3, 2013.
- On July 13, 2013 the injured Worker was evaluated by The Provider as requested.
- The provided documentation entitled “Qualified Medical Evaluation” was reviewed and compared to the guidelines as dictated in the Med-Legal OMFS. The OMFS determines the level of a Medical Legal Evaluation by Complexity Factors. The following complexity factors were abstracted from the QME Report:
 1. Four or more hours spent on any combination of two 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** – The Provider Reports: “120 minutes fact to face time,” and “5 hour(s) and 15 minutes of record review time.”

2. Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors.
 - **Criteria Not Met**
 - Requirement of “two or more hours of medical research by the physician,” not documented.
 - Med. Legal OMFS states, “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.” This evidence could not be found in the documentation provided.
 3. 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** – Requested By Claims Administrator. Findings on Page 11 & 12 of the QME report under the heading, “Causation.”
- OMFS ML 104 Criteria states “4 of More Complexity Factors.” Only 3 Complexity Factors were abstracted from provided QME Report.
 - Based on the aforementioned guidelines when compared to the documentation provided, the Provider has met the Criteria for OMFS ML103: “Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors.”
 - OMFS ML 103 = \$937.50

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML104 is not warranted based on the aforementioned guidelines when compared to the documentation provided. Documentation supports Claims Administrators reimbursement for ML103.

The table below describes the pertinent claim line information.

Date of Service: 7/13/2013							
Medical Legal Services							
Service Code	Provider Billed` -	Plan Allowed	Dispute Amount	Assist Surgeon	UNITS	Workers' Comp Allowed Amt.	Notes
ML104 (ML103)	\$2,437.50	\$937.50	\$ 1,500.00	N/A	1	\$937.50	Disputed Service: Code assignment of ML103 correct, no additional reimbursement recommended

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