

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 19, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000702	Date of Injury:	02/02/2012
Claim Number:	[REDACTED]	Application Received:	11/06/2013
Claims Administrator:	[REDACTED]	Assignment Date:	06/09/2014
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.

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 \$335.00 for the review cost and \$937.50 in additional reimbursement for a total of \$1272.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1272.50 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,

[REDACTED]
Chief Coding Reviewer

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: None
- National Correct Coding Initiatives
- Other: Medical Legal Fee Schedule in effect July 1st, 2006

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:** The dispute regards the payment amount for Med-Legal services ML104 for date of service 3/13/2013. The Provider billed ML104, was reimbursed \$937.50 and is requesting additional reimbursement of \$937.50. The Claims Administrator based its reimbursement of ML104 on ML 103 indicating "The documentation does not support the level of service billed. Reimbursement was made on a code that is supported by the desc."
- The description of Medical-Legal code ML104 is " Comprehensive Medical-Legal evaluation involving extraordinary circumstances." The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:
 1. An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. 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.
 2. An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;

- 3. A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.
 - The description of Medical-Legal code ML103 is " Complex comprehensive Medical-Legal evaluation." The criteria for ML103 requires three of the ten complexity factors to be met and documented by the Provider.
- The description of the ten complexity factors listed in Medical-Legal code ML103 are as follows:
 - 1. Two or more hours of face-to-face time by the physician with the injured worker.
 - 2. Two or more hours of record review by the physician.
 - 3. Two or more hours of medical research by the physician.
 - 4. Four or more hours spent on any combination of two complexity factors (1-3), which shall count as two complexity factors.
 - 5. Six or more hours spent on any combination of three complexity factors (1-3), which shall count as three complexity factors.
 - 6. Addressing the issue of medical causation upon written request of the party or parties requesting the report, or if a bonafide issue of medical causation is discovered in the evaluation.
 - 7. Addressing the issue of apportionment, when determining 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 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.
 - 8. Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances.
 - 9. A psychiatric or psychological evaluation which is the primary focus of the Medical-Legal evaluation.
 - 10. Addressing the issue of denial or modification of treatment by the Claims Administrator following utilization review under Labor Code section 4610.
 - Authorization letter requested the Provider's opinion as to causation of any psyche injury. Further requests included: "...a complete history, including a report of the injury, prior status, clinical chronology, current status, and past medical history. Please compare the history provided by the applicant with the history documented in the medical records." All which are detailed in Provider's report.
 - Provider documents 1 hour of face-to-face interview time with the injured worker, 1.5 hours reviewing the medical records, and 5 hours preparing this report.
 - Provider addresses Causation in his report to satisfy complexity factor #6 of ML103 by detailing History of Injury on page 3, 4 and 5 of report submitted.

- The complexity factor of apportionment was also met. The evaluation and apportionment determination was based on Provider’s recommendation of “I would apportion 80% of injured workers permanent psychiatric injury to the industrial cause. Of the 80% I would apportion 90% to the emotional shock of the assault and 10% to the physical injury to his arm. I would apportion 5% to ongoing intermittent pain from his little finger fracture and 0% to his low back injuries. In addition, I would apportion 15% to non-industrial causes stemming from vulnerabilities due to life stresses and losses detailed above.” Satisfying #7 complexity factor of ML103.
- #9 complexity factor states “A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation” and the reason for the request of the Medical Legal evaluation of this injured worker and which is satisfied in Provider’s report.
- Last complexity factor met in the Provider’s report is: #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. Claims Administrator requests Provider’s evaluation in the authorization and states: “The orthopedic component of the claim was accepted, however, parties are seeking your opinion as to causation of any psyche injury.” Provider has documented all psyche evaluation and physical injuries in the detailed report submitted.
- Based on the documentation submitted, the requirements of ML104 were met and warrant reimbursement. The provider billed and documented a total of thirty units for ML104.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code ML 104 is recommended.

Date of Service: 3/13/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
ML 104	\$1875.00	\$937.50	\$937.50	30 Units	N/A	\$1875.00	DISPUTED SERVICE: Allow reimbursement \$937.50

Copy to:

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