

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 17, 2014

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

<b>IBR Case Number:</b>	CB14-0000945	<b>Date of Injury:</b>	11/20/1997
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	07/02/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	09/22/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	ML104-93		

Dear [REDACTED] [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 \$250.00 for the review cost and \$26,062.50 in additional reimbursement for a total of \$26,312.50. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$26,312.50 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]  
[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
- Official Medical 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 disputing reimbursement for ML104-93 Med-Legal services provided to Injured Worker on 09/18/2013.
- Claims Administrator denied services stating “excessive and unreasonable” charge.
- Total Billed Charges: \$26,062.50
- Provider Reimbursed: \$0.00
- **Letter of Authorization** from (Legal Party) dated September 13, 2013, addressed to Provider, confirming the request for evaluation to address the following (as listed on authorization):
  - What is the likely cause of her symptoms? What injury is the likely cause of her fibromyalgia if any?
  - Given the applicant reports her symptoms occurring after the 2d injury, is there medical support for the conclusion that the 8/28/01, specific incident was the sole or greater cause of her fibromyalgia and/or other ailment or pathology, if any?
  - If the CT injury is the cause of the fibromyalgia, which particular body part identifies or confirms its onset? Please Explain.
  - What is the medical and scientific evidence for your conclusions, if any?
- Claims Administrator specific concerns regarding Med-Legal Exam Report are as follows:
  - Qualifications of Provider
  - More than one diagnosis referenced/researched/addressed.
  - Total time spent on face-to-face
  - Total time spent on record review
  - Total time spent on research

- Evidentiary standing of report
- Length of Report
- Total time spent report preparation.
- **Letter of Authorization** from (Legal Party) dated September 13, 2013 states copy of authorization submitted to Claims Administrator.
- Evidence from Legal Parties/Claims Administrator contesting the letter of Authorization prior to, or after, 09/18/2013, and before Invoice for Med-Legal Services, could not be found during IBR.
- Evidence disputing the Providers Qualifications before 10/17/13 Invoice from Provider for Med-Legal Services could not be found during IBR.
- Evidence of Contractual Agreement between Provider and Claims Administrator for flat rate reimbursement on Med-Legal Services could not be found during IBR.
- Fibromyalgia and its effects on the body as a whole, for example, urinary, psychological, can be found on pages 213-223.
- **Article 5.6 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations §9793 (h)** "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:
  - (1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.
  - (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
- **Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:**
  - (1) 2 or more hour's Face-to-Face time – **Criteria Met.**
  - (2) 2 or more hours Record Review – **Criteria Met.**
  - (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 Met** – in accordance with **§9793 (j):** "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.

**Excerpts and references can be found on page 197 through 236 of the Med-Legal Report under the heading, "Medical Research."**

- (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 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.” Request for Causation can be found on Authorization, Page 1, issue 5. **Criteria Met**
- (7) Apportionment – **Criteria 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 Not 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. Date of QME 03/27/2014. **Criteria Not Met,**
- **Five (5)** Complexity Factors Abstracted From Med-Legal Report.
- **ML104** – Attestation pursuant to §9795 Reasonable Level of Fees for Medical-Legal Expenses included in Examination Report, signed by Provider on page 237 of Med-Legal Report.
- **Modifier -93:** Interpreter - Applicable to ML102 and ML103 services only.
- Time Factors as stated on signed attestation:
  - Face to Face: 6.3 hours = 25.2 Units
  - Record Review: 97.9 hours = 391.60
  - Research: As Above
  - Report Prep: As Above.
  - Total Units = 417 Units
  - Documented time intervals page 238 of Med-Legal Report.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation, reimbursement is warranted for ML104-93 services.**

<b>Date of Service:</b> 09/18/2013							
<b>Med. Legal Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>

ML104-93	\$26,062.50	\$0.00	\$26,062.50	N/A	417	\$26,062.50	<b>\$26,062.50 Due Provider</b>
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