

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 10, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001823	Date of Injury:	09/12/2011
Claim Number:	[Redacted]	Application Received:	11/25/2014
Claims Administrator:	[Redacted]	Assignment Date:	01/02/2015
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 \$250.00 for the review cost and \$6,212.50 in additional reimbursement for a total of \$6,462.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$6,462.50 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,

Paul Manchester, M.D., M.P.H.
Medical Director

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
- Med Legal 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 seeking full remuneration for Med-Legal ML104 services performed on 07/15/2014.**
- Claims Administrator reimbursed \$3,425.00 of \$9,637.540 with the following rationale: “The charge exceeds the Official Medical Fee Schedule allowance the charge has been adjusted to the schedule allowance.”
- Authorization for services electronically stamped by fax on 7/14/2014, signed by the Claims Administrator’s Legal Party, addressed to the Provider reflects authorization for Med-Legal Services per the Provider’s “usual comprehensive and thorough reporting.”
- Authorization does not specify level of service or a specific monetary amount.
- **ML104 Med - Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- **Evaluation of ML-104 Documentation compared to ML104 OMFS guidelines of “4 or more complexity factors” requirement:**
 - (1) 2 or more hours Face-to-Face time – **Criteria Met**
 - (2) 2 or more hours Record Review – **Criteria Met**
 - medical records for review at the time of her examination.”
 - (3) Two or more hours of medical research by the physician; **Not Indicated**

- 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” **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 (2)**
- (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.” Request for Causation can be found on Authorization, Page 2, issue 10. **Criteria Met (3)**
- (7) Apportionment – **Criteria Not Met** - Percentage of Apportionment not indicated. Page 34, paragraph 2, the provider states, “As I do not think that (Injured Worker) is Permanent and Stationary and at Maximum Medical Improvement, I defer apportionment.”
- (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 (4)**
- (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 07/15/2014 **Criteria Not Met,**
- **Four (4)** Complexity Factors Abstracted From 07/15/2015 QME Report.
- Time Factors as presented in QME Report :
 - Face to Face: 2.25 hours = 9 Units
 - Record Review: 12.25 = 49 Units
 - Report Prep: 23.25 hours = 93 Units
 - 37.75 Hours = 151 Units
- Criteria met for ML104, additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 07/26/2014							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$9,937.50	\$3,425.00	\$6,212.50	N/A	151	\$9,937.50	Disputed Amount Due Provider. Refer to Analysis

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