

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 10, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001895	Date of Injury:	06/01/2011
Claim Number:	[Redacted]	Application Received:	12/09/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/7/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML-104-95		

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 \$1000.00 in additional reimbursement for a total of \$1250.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1250.00 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, MD, MPH
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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Reasonable Fees for Medical Legal Expenses

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 is dissatisfied with denial of ML 104-95
- Claims administrator denied ML 104-95 indicating on the Explanation of Review “Complexity factors must be clear and concise. Combined times are not appropriate. Please resubmit with itemized and separate time factors for (Face-to-Face, Record Review, Research). Note Report Preparation is not a recognized complexity factor and cannot be combined with the aforementioned elements.”
- Provider was asked to perform a re-evaluation on the injured worker.
- Report submitted documents all areas requested by claims examiner and documents 2 hours face-to-face time, 6 hours for review of medical records and report preparation, plus Causation and Apportionment are clearly defined at the end of the report.
- ML 104 - *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: An evaluation which requires four or more of the complexity factors listed under ML 103
- ML 103: *Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below.
- In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following 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: 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 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; 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; 7- Addressing the issue of apportionment;

- As claims administrator does mention that report preparation is not one of the complexity factors accepted as part of reimbursement, and provider did not submit new documentation to determine how much time was spent on medical record review, only complexity factor 4- above may be used, not 5-.
- Provider meets criteria: 4-, 6- and 7- which totals four complexity factors as mentioned in ML 104 description.
- Based on information reviewed, reimbursement of ML 104-95 is warranted for 16 units.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104-95 is recommended.

Date of Service: 6/9/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 104-95	\$2000.00	\$0.00	\$2000.00	16	Percent reduction	\$1000.00	DISPUTED SERVICE: Allow reimbursement \$1000.00

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