

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 25, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001912	Date of Injury:	02/06/2014
Claim Number:	[REDACTED]	Application Received:	12/10/2014
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: 1/21/2015

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 \$2625.00 in additional reimbursement for a total of \$2875.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2875.00 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

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
- National Correct Coding Initiatives
- Other: Medical-Legal 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 is disputing the denial of Medical Legal Code ML104.
- The supplied medical record, provided documentation and support for ML104
- ML104: An evaluation which requires four or more of the complexity factors listed under ML 103
- Provider documented a total of 10.5 hours spent on ML evaluation & report: 2 hours 30 minutes face-to-face time; 1 hour 30 minutes record review; and 6 hours 30 minutes producing report.
- The medical record demonstrated the following four complexity factors:
 - (4) Four or more hours spent on any combination of two complexity factors (1)-(3), which shall count as two complexity factors (**1st & 2nd complexity factors**)
 - 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 (**3rd complexity factor**)
 - Addressing the issue of apportionment, when determination of 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 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 (4th complexity factor)

- The documentation included an Attorney request for the QME, authorizing the exam and request for CT (Cumulative Trauma) etiology.
- Additional reimbursement recommended for ML104 x 42 units (10.5 hours).

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code: ML104.

Date of Service 9/8/2014							
Medical-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML104	\$ 2,625.00	\$ 0.00	\$ 2625.00	42	N/A	\$ 2625.00	DISPUTED SERVICE: Additional reimbursement warranted in the amount of \$2625.00

Copy to:

██████████
 ██████████
 ████████████████████

Copy to:

██
 ██
 ████████████████████