

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 19, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001916	Date of Injury:	03/04/2012
Claim Number:	[Redacted]	Application Received:	12/11/2014
Claims Administrator:	[Redacted]		
Assigned Date:	1/20/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML-104-95-25		

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 \$937.50 in additional reimbursement for a total of \$1187.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1187.50 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, 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: §9795 Reasonable Level of 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 code ML 104-95
- Claims administrator denied ML 104-95 indicating on the Explanation of Review “Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure.”
- Provider billed ML 104-95 on a CMS 1500 form alone as there are no other procedure codes listed on the form. EORs received do not show any other procedure codes were submitted for review as well.
- Provider was requested by the defendant’s attorney to act as a QME for the injured worker’s claim.
- Provider’s report submitted documents ML 104-95 meeting 4 complexity factors which he lists as: 1 hour of record review time; 90 minutes of face-to-face time; 2 hours of report preparation (this does not qualify as a complexity factor and is omitted from the calculations); 4.5 total hours of combined time; hours or more of any combination of 3 complexity factors; addressing issues of causation and addressing issues of apportionment.
- Provider’s report does not address Causation only Apportionment and therefore that factor is omitted from the calculation.
- ML 103 - *Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below. (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; (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report; (7) 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.

- Provider's report qualifies #4 and #7 for a total of 3 complexity factors met and therefore reimbursement of ML 103-95 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 6/26/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 103-95	\$1125.00	\$0.00	\$1125.00	N/A	N/A	\$937.50	DISPUTED SERVICE: Allow reimbursement \$937.50

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