

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 6, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000112	Date of Injury:	07/06/2011
Claim Number:	[REDACTED]	Application Received:	01/26/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	2/12/2015		
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 \$195.00 for the review cost and \$312.50 in additional reimbursement for a total of \$507.50. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$507.50 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: 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 dissatisfied with reimbursement of ML 104
- Claims administrator down coded ML 104 to ML 102 indicating on the Explanation of Review “Documentation doesn’t support the level of services” and “Lower ML 104 to ML 102. Based on the documentation the following factors were met for determining the level of reimbursement: 1, 2. However per the ML FS the following are not considered factors or were not met 6 & 7.”
- 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 complexity factors (1-3), which shall count as two complexity factors.
  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, or if a bona-fide issue of medical causation is discovered in the evaluation.

7. Addressing the issue of apportionment, when determining 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.

8. Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances.

9. A psychiatric or psychological evaluation which is the primary focus of the Medical-Legal evaluation.

10. Addressing the issue of denial or modification of treatment by the Claims Administrator following utilization review under Labor Code section 4610.

- (j) "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts.
- Section 9795(c) ML103 & ML 104 – Complexity Factor (3): Physicians are required to excerpt or furnish copies of medical evidence relied upon when requesting medical-legal reimbursement for complexity factor (3) when the physician performs 2 or more hours of medical research.
- Provider did not document any evidence of medical journals or texts and therefore cannot be counted as one of the complexity factors.
- Provider does document complexity factors 1, 2 and 6 which does qualify the Medical Legal as 103 and therefore additional reimbursement is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code ML 103 is recommended.

<b>Date of Service:</b> 4/22/2014							
<b>Medical Legal Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 103	\$5375.00	\$625.00	\$4750.00	86	N/A	\$937.50	<b>DISPUTED SERVICE:</b> Allow reimbursement \$312.50

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]