
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 10, 2015

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000711	Date of Injury:	12/07/2012
Claim Number:	[REDACTED]	Application Received:	05/06/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/02/2014 – 12/02/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-94 (down coded to ML102)		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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 reimbursement of ML 104-94
- Claims Administrator reimbursed ML 104-94 as ML 102 indicating on the Explanation of Review “Based on documentation the following factors were met for determining the level of reimbursement: Factor 4. However per the ML FS the following are not considered factors or were not met: 6 and 7”
- Letter dated November 12, 2014 requests Provider as a Panel QME. Therefore, modifier - 94 is inappropriate to bill and warrants zero reimbursement.
- Provider’s report submitted documents “This report is submitted pursuant to 8 Cal. Code. Regs. Section 9795 (b) & (c) as an ML 104, Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances (with panel Qualified Medical Evaluation modifier -95) and meets the requirement of five complexity factors: (1-3) 6+ hours spent on any combination of three of the complexity factors (1) – (3), which shall count as three complexity factors; (4) Addressing medical causation, which shall count as one complexity factor; (5) Addressing apportionment, which shall count as one complexity factor”
- Provider documents 3 hours of fact-to-face time, 2 hours of Record Review time, 2 hours of report preparation for a total of 7 hours.

- Report preparation is not one of the complexity factors and cannot be counted as such for determining the medical legal level. Therefore, 6+ hours is truly 5 hours and is only counted as 2 complexity factors not 3.
- Provider's report also titles Causation and Apportionment, however, no details are given to support either of these complexity factors.
- Based on documentation reviewed, reimbursement of ML 104 is not warranted and ML 102 is the appropriate Medical Legal level.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 12/2/2014						
Medical Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 102	\$2,187.50	\$625.00	\$1562.50	N/A	\$625.00	DISPUTED SERVICE: No further reimbursement is recommended.

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