MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 10, 2015

[redacted]

IBR Case Number:	CB15-0000758	Date of Injury:	04/04/2014
Claim Number:	[redacted]	Application Received:	05/13/2015
Claims Administrator:	[redacted]		
Date(s) of service:	11/18/2014		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	ML104-94		

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]

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:

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 down coded ML 104 to ML 103 indicating on the Explanation of Review "Based on the documentation the following factors were met for determining the level of reimbursement: Face to face, record review and Causation. However per the ML FS the following are not considered factors or were not met: Apportionment."
- Provider's report submitted documents complexity factors as record review addendum with no time units showing, 2 hours for the physical examination and history of this consultation, 0.25 hour on medical research, and Causation. Apportionment was mentioned as being addressed at a later date. Provider also documents six or more combined hours were spent, however, six hours were not documented.
- ML 104 requirements: (1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the 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. (2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three

or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician; (3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

- Based on information reviewed, Provider's report does not support reimbursement of ML 104 and therefore no further reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 103-94

Date of Service: 11/18/2014						
Medical Legal Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
ML 103-94	$3125.20	$1171.88	$1953.32	N/A	$1143.75	**DISPUTED SERVICE**: No further reimbursement recommended

Copy to:

[redacted]

Copy to:

[redacted]