

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 22, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0001002	Date of Injury:	06/04/2012
Claim Number:	[Redacted]	Application Received:	06/19/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	07/29/2014		
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 \$1612.03 in additional reimbursement for a total of \$1807.03. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1807.03 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, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

## 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 “The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the documentation submitted with the billing.”
- Provider was requested as a Qualified Medical Evaluator in the field of orthopedic surgery.
- ML 103 - (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; (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;
- ML 104 - (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.

- Report submitted by Provider documents at the beginning “The complexity of this evaluation/report qualifies for ML104 billing per Title 8, California Code of Regulation, Sections 9793, 9795. For aesthetic and logistical purposes, the complexity factors are clearly and concisely outlined at the end of this report”. At the end of the report Provider documents 2 hours face-to-face, 4 hours of record review and .25 hour of medical research. Provider documents six or more combined hours as criteria #5 of the ML 103 component. Medical evidence was attached at the end of the report. Provider also addresses Causation to meet the standard of ML 104.
- Based on information reviewed, additional reimbursement of ML 104 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104**

<b>Date of Service:</b> 07/29/2014						
<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>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 104	\$2425.33	\$700.47	\$1724.86	37	\$2312.50	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1612.03

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