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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 8, 2016

[redacted]

IBR Case Number:	CB16-0000053	Date of Injury:	03/20/2014
Claim Number:	[redacted]	Application Received:	01/12/2016
Claims Administrator:	[redacted]		
Date(s) of service:	07/13/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	ML104-95		

Dear Robert Fisher, MD:

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 $4,312.50 in additional reimbursement for a total of $4507.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$4507.50** 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, M.D., M.P.H.
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
- Med Legal Official Medical 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 disputing reimbursement for ML104-95 services submitted for date of service 07/13/2015.**
- The Claims Administrator down coded ML 104 to a ML 103 and reimbursed services $937.50 with the following rational: "the charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance."
- Communication dated June 3, 2015, generated by legal party, identifies the Provider as the requested Panel QME for date of service 7/13/2015.
- **Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:**
    - (1) 2 or more hours Face-to-Face time
    - (2) 2 or more hours Record Review
    - (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."
    - (5) "Six or more hours spent on any combination **of three complexity factors (1)-(3),** which shall count as three complexity factors." **Criteria Met: 2.0 hour for history and physical examination time with patient; 12 hours of record review; and 1**

<u>hour of medical research (6.0 hours report preparation, writing and editing)</u>. Appendix B at the end of Provider's report documents medical research Provider reviewed.

- (6) Causation – "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." **Criteria Met on page 43 of Provider's report.**
- (7) Apportionment – **Criteria Not Met.**
- (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances; **Criteria Not Met.**
- (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Not Met – QME Request does not indicate psychiatric or psychological evaluation.**
- (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met**.

- **Three (4)** Complexity Factors Abstracted From QME Report.
- ML104 requires: (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.
- Criteria met for **ML104.**
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for ML104.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104-95

Date of Service: 07/13/2015							
Med Legal Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
ML104	$5250.00	$937.50	$4312.50	N/A	84	**$5250.00**	$4312.50 Due to Provider

Copy to:

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