

**MAXIMUS FEDERAL SERVICES, INC.**

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

May 3, 2016

[Redacted]

IBR Case Number:	CB16-0000567	Date of Injury:	09/10/2012
Claim Number:	[Redacted]	Application Received:	04/11/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	11/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104 (downcodes to ML103)		

[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
- National Correct Coding Initiatives

## 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 seeking remuneration of ML 104 performed on date of service 11/19/2015.
- Claims Administrator down coded ML 104 to ML 103 indicating "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"
- Request for Qualified Medical Evaluator was submitted for review.
- **§ 9795 Reasonable Level of Fees for Medical-Legal Expenses (c) ML104 (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.
- Page 2 of Provider's report documents "This report is submitted as an ML-104, Complex Comprehensive Medical-Legal Evaluation and meets the requirement of four or more complexity factors."
- Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:
  - (1) 2 or more hours Face-to-Face time: **Criteria Met** 2 hours of face-to-face time
  - (2) 2 or more hours Record Review: **Criteria Met** 16.75 hours of Record Review
  - (3) Two or more hours of medical research by the physician; **Criteria Not Met**

- (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. **Criteria Met.**
  - (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors. **Criteria Not Met** (documentation must support face-to-face, record review AND medical research to be considered factor #5)
  - (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 Not Met as Provider defers this factor.**
  - (7) Apportionment – **Criteria Not Met – Provider defers this factor.**
  - (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 Met**
  - (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 (3) Complexity Factors Abstracted From QME Report**
- **Administrative Rules § 9795:** (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate three or more injuries or pathologies, or the claimant's employment by three or more employers.
  - Provider was requested to address Causation which he defers in his report. Therefore, Causation and Apportionment, which is also deferred, cannot be counted as complexity factors.
  - Based on guidelines and documentation reviewed, additional reimbursement for ML 104 is not warranted.

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104

<b>Date of Service:</b> 11/19/2015						
<b>Medical Legal</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>
ML103	\$7062.50	\$937.50	\$6125.00	1	\$937.50	Refer to Analysis

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]