

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 18, 2016

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

IBR Case Number:	CB16-0000656	Date of Injury:	09/26/2014
Claim Number:	[REDACTED]	Application Received:	04/20/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/18/2016		
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, M.D., M.P.H.
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
- 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 seeking remuneration for ML104-94 services performed on 01/18/2016.**
- The Claims Administrator reimbursed ML 104-94 however, down-coded total units based on elements of report.
- Authorization from Legal Parties to Provider confirms request for AME services, relating to the field of orthopedics.
- The following requests are noted on the October 13, 2015 Authorization:
 - Address multiple direct issues/questions/concerns including:
 - Causation
 - Apportionment
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...” MI104 (3)(i) (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: relevant the records, **face-to-face time** with the injured worker, preparing the report and, if applicable, any other activities.
- Med Legal OMFS ML104 criteria when compared to abstracted information provided on the AME report revealed the following:
 1. Two or more hours of face-to-face time by the physician with the injured worker. **Unable to Determine** – Report Reflects “fourteen hours and fifteen minutes in face to face time

- and** in review of medical records.” **Actual Face-to-Face time is unclear. Criteria Not Met.**
2. Two or more hours of record review by the physician **Unable to Determine** – Report Reflects “fourteen hours and fifteen minutes in face to face time **and** in review of medical records.” **Actual Record Review time is unclear. Criteria Not Met.**
 3. Two or more hours of medical research by the physician. Not Indicated – **Criteria Not Met**
 4. Four or more hours spent on any combination of **two** 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 Not 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**
 6. 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.**
 7. Addressing the issue of Apportionment under the following circumstances: **Criteria Met.**
 8. 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**
 10. Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met.**
- ML104 (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 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
 - if applicable, any other activities.
 - Criteria was not met for ML104 services, however would qualify as ML 102.
 - Based on documentation and guidelines, additional reimbursement of ML 104-94 is not warranted.

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

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 1/18/2016					
Med Legal Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Notes
ML104	\$11,641.37	\$4,453.13	\$7,188.24	149	Med Legal OMFS

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]