

**MAXIMUS FEDERAL SERVICES, INC.**

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

May 31, 2016

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

IBR Case Number:	CB16-0000734	Date of Injury:	06/19/2014
Claim Number:	[REDACTED]	Application Received:	05/02/2016
Assignment Date:	05/23/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/03/2015 – 12/03/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104 x 38		

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,  
MAXIMUS

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 OMFS

## 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 billed Med-Legal ML104-92 services submitted for date of service 12/03/2015.**
- Claims Administrator denied reimbursement for services with the following rationale: “Documentation does not support the level of service billed.”
- **Title 8, California Code of Regulations, Chapter 4.5, Division of Workers’ Compensation Subchapter 1, Administrative Director – Administrative Rules, Article 5.6 Section 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony. (c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows: ML104 Procedure Description: A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances.**
- Authorization for ML104 services could not be found within the documents submitted for IBR.
- Documentation does not include directives from Legal Parties for Med-Legal Services.
- **Evaluation Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:**
  - (1) **2 or more hours Face-to-Face time – Criteria Not Met,** Page 1, paragraph 4, of QME Report, the Provider States “**thirty minutes was spent in direct face-to-face time with the patient.**”

- (2) 2 or more hours Record Review – **Criteria Met**, Page 1, paragraph 5 of QME Report, Provider states, “**combination of 6 hours**” in addition to face to face time; total time is 5.5 hours of record review.
- (3) Two or more hours of medical research by the physician;
  - Med. Legal OMFS, “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 Not Met**
  - § 9793 (j): "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.”
- (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 Not Met - criteria 3 not reflected in report.**
- (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) 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**
  - **Directive from Claims Administrator/Legal Parties not received.**
  - **Unable to verify discovery of “bona fide issue of medical causation” as past history or directive from Claims Administrator/Legal parties was not available for review.**
- (7) Apportionment – **Criteria Not Met.** Page 20 of QME report, the Provider indicates, “I cannot provide a definitive opinion on apportionment until she has reached maximum medical improvement.”
  - LC 4663. (a) Apportionment of permanent disability shall be based on causation.
  - (b) Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.
  - (c) In order for a physician's report to be considered complete on the issue of permanent disability, it **must include an apportionment determination.** A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior

condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination. (Emphasis added)

- (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**
  - **Directives from Legal Parties not available to confirm 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, Date of QME 08/24/2014.**
- **One (1) One Complexity Factor Abstracted from QME Report; criteria not Met for ML104 services.**
- **Based on the aforementioned documentation and guidelines, reimbursement for ML104 services is not indicated.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: ML104-92**

<b>Date of Service:</b> 12/03/2015							
<b>Med-Legal Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML104	\$2,375.00	\$937.50	\$1,437.50	N/A	38	\$937.50	<b>Refer to Analysis</b>

Copy to:

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