

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 18, 2014

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

<b>IBR Case Number:</b>	CB14-0001312	<b>Date of Injury:</b>	04/09/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	09/09/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	10/06/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	ML103-95		

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,

[REDACTED]

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 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 full remuneration for ML103-95 services performed on 04/08/2014.
- Claims Administrator down-coded ML103-95 to ML102-95 referring to elements of ML103 as not being met.
- Total Billed Charges: \$937.50
- Provider Reimbursed: \$625.00
- Claims Administrator is not disputing Med Legal Services.
- Claims Administrator is disputing Elements of ML103-95 vs. ML102-95.
- **Article 5.6 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations §9793 (h)** "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:
  - (1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.
  - (2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who

requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues

- **Evaluation Documentation compared to ML103 OMFS “3 or more complexity factors” requirement:**
- (1) 2 or more hours Face-to-Face time = “60 minutes.” **Criteria Not Met,**
- (2) 2 or more hours Record Review = “3 hours” **Criteria Met.**
- (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** – in accordance with §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 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) 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 – Request not found on March 12, 2014 Authorization for services from (Legal Parties).**
- (7) Apportionment – **Criteria Not Met – Provider states, page 13 of QME Report, “... will be a factor when the patient is declared permanent and stationary.”**
- (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**
  - (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. Date of QME 03/27/2014. **Criteria Not Met,**
- **Two (2) Complexity Factors Abstracted From QME Report.**
- **Criteria not met for ML103-95 services.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation, reimbursement is warranted for ML103-95 services.**

Date of Service: 03/27/2014

**Med. Legal Services**

<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>
ML103-95	\$937.50	\$625.00	\$312.50	N/A	1	\$625.00	Refer to Analysis

Copy to:

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

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]