

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000702	Date of Injury:	09/25/2009
Claim Number:	[Redacted]	Application Received:	05/06/2014
Claims Administrator:	[Redacted]	Assignment Date:	09/11/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104 and ML106		

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: 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 \$250.00 for the review cost and \$8,875.00 in additional reimbursement for a total of \$9,125.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$9,125.00 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,

[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 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 and ML106 services.**
- Claims Administrator down coded ML104 to ML103 referencing time spent on services as “excessive.”
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- **ML104 Complexity Factors 1 – 10 of 10** Compared to 1/31/2013 QME Report:
 - (1) Two or more hours of face-to-face time by the physician with the injured worker. **Provider Indicates, “2 hours 15 min.”**
 - (2) Two or more hours of record review by the physician. **Provide Indicates, “12 hours 45min.”**
 - (3) Two or more hours of medical research by the physician. Must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon: **Criteria Not Met** (excerpts can be found under the heading “Apportionment of Disability Related to Smoking” and “Apportionment of Disability Related to Body Weight,” on QME report, however guidelines require a separate works cited page.
 - (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) Addressing the issue of medical causation, upon written request: **Criteria Met**

Authorization from (Legal Parties) requests the Provider address causation relating to Injured Workers: spine, left hip degeneration, right hip degeneration, weight, tobacco use, self-employment, MVA 1993, specific injury 9/24/09, and CT through Injured Worker's date of retirement.

(7) Apportionment: **Criteria Met**

(8) Medical Monitoring of an employee following a toxic exposure to chemical mineral or biological 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.**

- Abstracted information from QME report meets the Complexity Factor requirement for ML104 service code.
- A statement in relation to time limits associated with ML104 service cannot be found in the Med-Legal OMFS or associated Labor Codes.
Labor Code 4625 (j) directs a Provider to sign an attestation under penalty of perjury that the reported information is "true and correct" to the best of undersigns "knowledge."
- Signed Attestation on page 5 of the QME report reflects LC 4625 (j) declaration with additional lines stating, "I have fully complied with labor code 4628. The contents of the report and bill are true and correct to the best of my knowledge."
- ML104 Time Factors as recorded and abstracted from the QME report.
 - Face-to-Face time: 2 hours 15 Min
 - Review of Records: 12 hours 45 min
 - Research: 2 hours 30 min
 - Preparation of Report: 21 hours 45 min
 - Total: 39 hours 15 min = 157 units @ 62.50 = \$9,812.50
- **ML106:** Claims Administrator down-coded service to 99080 and was reimbursed "\$0.00" dollars for the down-coded service stating, "code not reimbursable under the California Code of Regulations."
- **ML106 Med. Legal Definition:** Fees for supplemental medical-legal evaluations.
- Documentation provided does not indicate the report is a "supplemental" finding to an existing evaluation where a Medical Opinion of the Injured Worker was rendered. It is a letter to the Claims Administrator regarding "usual and customary" fees.
- **CPT Code 90899: Reports**
- Down-coded service does not qualify for "Treatment Reports" under §9789.14, Reimbursement for Reports, Duplicate Reports, Chart Notes.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Is based on the aforementioned documentation and guidelines for ML104 and ML106 services.

Date of Service: 01/06/2014							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104 as ML103	\$9,812.50	\$937.50	\$8,875.00	N/A	157	\$9,812.50	\$937.50 Reimbursed to Provider – WC Allowed Amount = \$ 8,875.00 Due Provider for ML104 Service
ML106 as 90899	N/A	N/A	N/A	N/A	N/A	N/A	Refer to Analysis

Copy to:

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