

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 12, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0000733	<b>Date of Injury:</b>	4/29/2011
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	5/12/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	7/24/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	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,

[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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Medical-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 is dissatisfied with reimbursement of ML 104-94.
- Claims Administrator down coded ML 104-94 to ML 103-95 indicating on the Explanation of Review “Allowance has been recommended based on the level of service documented in the report.”
- ML 103-Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth below. In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. 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: (1) Two or more hours of face-to-face time by the physician with the injured worker; (2) Two or more hours of record review by the physician; (3) Two or more hours of medical research by the physician; (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; (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors; (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; (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference. (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; (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal 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.

- ML 104 - Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following: (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. 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. (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 three or more hours of record review by the physician; (3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (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: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.
- -94 Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25.
- Letter dated August 16, 2013 from Claims Administrator states an agreement of Qualified Medical Examiner with the Provider. Nothing was reviewed stating a request for Agreed Medical Evaluator as appended by modifier -94 billed by Provider. Therefore, Claims Administrator was correct in applying the -95, modifier Evaluation performed by a panel selected Qualified Medical Evaluator.

- Provider states “Reduction of service to ML 103-95 is inappropriate. We documented 4 complexity factors including 6 or more hrs in any condination=3 factors the 4<sup>th</sup> is causation.” Provider’s report documents 80 minutes of face-to-face time with patient and “The review of medical records took an additional 330 minutes.” Nothing was documented regarding medical research as described in (3) of ML 103 description. Hours completed would result in (4) of ML 103 which would be 2 complexity factors. Causation was addressed (briefly) which qualifies as one complexity factor. No apportionment was mentioned.
- Based on information reviewed, Claims Administrator was correct to reimburse Provider based on a ML 103-95. Therefore, no additional reimbursement is recommended.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information received, additional reimbursement of code ML 104-94 is not warranted.**

Date of Service: 9/11/2013							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
ML 103-95	\$2409.38	\$937.50	\$1471.88	N/A	N/A	\$937.50	<b>DISPUTED SERVICE:</b> No reimbursement is recommended

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