

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 9, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000778	Date of Injury:	07/31/2013
Claim Number:	[Redacted]	Application Received:	05/23/2014
Claims Administrator:	[Redacted]	Assignment Date:	07/14/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-95		

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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Labor Codes 4663 & 4664, §9795 Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

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 104-95. Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances.-95 Evaluation performed by a panel selected Qualified Medical Evaluator.
- Provider billed ML-104-95 per agreement with Claims Administrator that included specific requests. Claims Administrator reimbursed \$937.50 after reducing ML-104 to ML-103 and indicating on the Explanation of Review “Based on the documentation the following factors were met for determining the level of reimbursement: Face to face, record review, causation. However per the ML FS the following are not considered factors or were not met: apportionment is deferred.”
- Claims Administrator documented specific requests for the Provider to report after the patient examination and record review. Claims Administrator specifically requested “Please comment on all areas of apportionment, under the new AMA guidelines”.

- ML 103 - (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.
- Apportionment is the process in which an overall permanent disability that was caused at least in part by an industrial injury is separated into the components that are and are not compensable results of that injury. Report submitted for this review documents under Apportionment: "I am aware of the current Labor Codes of 4663 and 4464 and the Escobedo Law. Based on the MRI studies that have been done, apportionment may be an issue but this will be addressed when the patient is finalized."
- Provider fails to address the areas of apportionment requested by the Claims Administrator. Pursuant to Labor Code 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.
- Based on information received for this review, Claims Administrator is justified in reducing ML 104 to ML 103. Therefore, no further reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code ML 104-95 is not recommended.

Date of Service: 1/7/2014						
Medical-Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML 103-95	\$3125.00	\$937.50	\$2187.50	1	\$937.50	DISPUTED SERVICE: NO reimbursement recommended

Copy to:

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