

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 9, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0000802	<b>Date of Injury:</b>	11/02/2012
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	05/27/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	07/10/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	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: 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 \$562.50 in additional reimbursement for a total of \$812.50. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$812.50 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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: §9795 Reasonable Level of Fees for Medical-Legal Expenses

## 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.
- Claims Administrator reimbursed \$937.50 after down coding ML104 to ML 103 and indicating on the Explanation of Review “Based on the ML 104 report submitted only 3 Complexity Factors were supported. Therefore your services will be adjusted to ML 103 and no additional is due. Thank you.”
- 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.

- **ML 104 - Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances:** (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.
- Provider's report submitted documents a total of 4 hours of combined complexity factors (1) – (3) as addressed in ML 103 (4) for a total of two 2 complexity factors. Report preparation time does not count as one of the complexity factors. Also addressed in the report are ML 103 requirements (6) for Causation and (7) for Apportionment for a complete total of 4 Complexity Factors required in ML 104.

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 warranted.**

<b>Date of Service:</b> 1/8/2014						
<b>Medical-Legal Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 104-95	\$1500.00	\$937.50	\$562.50	1	\$1500.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$562.50

Copy to:

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

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]