

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 15, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000823	Date of Injury:	04/15/2013
Claim Number:	[Redacted]	Application Received:	06/05/2014
Claims Administrator:	[Redacted]	Assignment Date:	08/25/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104		

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 \$2062.50 in additional reimbursement for a total of \$2312.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2312.50 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]
[Redacted]

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 denial of ML 104, Comprehensive Medical-Legal Evaluation Involving Extraordinary Circumstances.
- Claims Administrator denied ML 104 indicating on the Explanation of Review “The services are for a condition(s) other than a covered work related injury or occupational disease disablement.”
- 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.

- Documentation received for this review includes a letter from Claims Administrator which states “Thank you for agreeing to examine Injured Worker in your capacity as a Qualified Medical Examiner. Please conduct a complete examination of the applicant and provide the parties with a narrative report containing your detailed findings and conclusions. You are authorized to conduct medical and diagnostic tests (short of hospitalization) needed to render your opinion.” The letter further goes on to request items to detail in the narrative report.
- Provider submitted CMS 1500 form billing ML 104 at \$2125.00 with 34 units. Report submitted documents Provider’s service description as 2.5 hours of face-to-face time with the patient, 5.75 hours of combined record review and medical research for a total of 8.25 hours. Provider also details Causation and Apportionment in this narrative report which qualifies as a ML 104.
- Based on the information reviewed, Provider is warranted reimbursement for his services requested by Claims Administrator.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code ML 104 is warranted.

Date of Service: 4/5/2014							
Medical-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
ML 104	\$2125.00	\$0.00	\$2125.00	33	N/A	\$2062.50	DISPUTED SERVICE: Allow reimbursement \$2062.50

Copy to:

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

Copy to:

[REDACTED]
 [REDACTED]
 [REDACTED]