

**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**

January 12, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001580	<b>Date of Injury:</b>	04/19/2011
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	10/21/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	11/13/2014
<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: 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
- Med-Legal OMFS

## 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 seeking remuneration for Med-Legal Services submitted as ML104 performed on May 23, 2014.
- Claims Administrator down-coded services from ML104 to ML102 based on the following rationale: “Your documentation of extraordinary circumstances does not justify the use of ML104. The evaluation does not meet the criteria listed in rule 9795(C) of ML104.”
- Communication 11/21/2014 from Claims Administrator to Provider refers to the Provider as the “Qualified Medical Evaluator” for case and refers to a “5/2013” and a January 2015” appointment.
- Above referenced communication does not indicate an agreement for “extraordinary circumstances” as required for ML104-95 services.
- **Evaluation Documentation compared to ML104-95 OMFS “4 or more complexity factors” requirement:**
  - (1) 2 or more hours, Face-to-Face time – **Criteria Not Met**, Provider does not specify specific number of time dedicated to “face-to-face” exam. Reported time, “4 hours,” combined “exam, report dictation, and review of dictation.”
  - (2) 2 or more hours Record Review – **Criteria Not Met**, Provider does not specify specific number of hours dedicated to “record review.” Reported time, “3-1/2 hours” combined “record review and medical research.”
  - (3) Two or more hours of medical research by the physician;

Med. Legal OMFS, “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” **Criteria Not Met** – in accordance with §9793 (j): "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.”

- (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 Not 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) Causation – “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.” **Criteria Not Met.** Request for Causation not indicated in the aforementioned communication from Claims Administrator
- (7) Apportionment – **Criteria Not Met** – percentage not indicated on QME report.
- (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; **Criteria Not Met.**
- (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Not Met**
  - (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. Date of QME 05/23/2014 **Criteria Not Met,**
- **Zero (0) Complexity Factors Abstracted From QME Report.**
- **ML104 Criteria Not Met**
- **ML103 Criteria Not Met**
- **Uphold ML102**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation, reimbursement is not warranted for ML104-95 services.**

Date of Service: 05/23/2014							
Med- Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104-95	\$1,875.00	\$625.00	\$1250.00	N/A	30	\$6,750.00	<b>\$6,750.00 Due Provider</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]