

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 6, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001613	Date of Injury:	04/15/2013
Claim Number:	[REDACTED]	Application Received:	10/27/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	2/12/2015		
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: 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 \$3937.50 in additional reimbursement for a total of \$4187.50. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$4187.50 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,

Paul Manchester, MD, MPH  
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: Medical Legal 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 code ML 104-95.
- Claims administrator down coded ML 104 to ML 103 indicating on the Explanation of Review "Billing greater than Medical Legal Allowance" and "Qualified Medical Examiner"
- The description of Medical-Legal code ML104 is "Comprehensive Medical-Legal evaluation involving extraordinary circumstances." The criteria for ML104 requires four or more of the ten complexity factors listed under ML103 to be met and documented by the Provider. The description of modifier 95 is "Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure." The description of Medical-Legal code ML103 is "Complex comprehensive Medical-Legal evaluation." The criteria for ML103 requires three of the ten complexity factors to be met and documented by the Provider.
- The Medical-Legal report submitted by the provider met the required four complexity factors. The provider documented four or more hours of record review and face-to-face time, which qualifies as two complexity factors. The provider addressed the issue of causation in the report. Addressing the issue of causation qualifies as one factor. The fourth complexity factor was met by the documentation of a psychological evaluation. The provider specified at the beginning of the report four complexity factors were met and documented in the Medical-Legal report. Although the combined face-to-face and record review do not total greater than 6 hours, the provider does address Causation and

this is a psychiatric evaluation. Therefore, a total of four (4) complexity factors are met which qualifies this Medical Legal as a ML 104.

- The documentation submitted supports the reimbursement of Medical-Legal code ML104 Modifier 95. The code assignment of ML103 paid by the Claims Administrator was inappropriate.
- Based on information reviewed, additional reimbursement of ML 104-95 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code ML 104 is recommended.

Date of Service: 7/3/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 104-95	\$4875.00	\$937.50	\$3937.50	78	N/A	\$4875.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$3937.50

Copy to:

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