

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 22, 2015

██████████
████████████████████
████████████████████

IBR Case Number:	CB15-0001445	Date of Injury:	04/02/2009
Claim Number:	██████████	Application Received:	08/25/2015
Claims Administrator:	████████████████████		
Date(s) of service:	03/02/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	ML104-94		

Dear ██████████

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 \$195.00 for the review cost and \$2656.25 in additional reimbursement for a total of \$2851.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2851.25 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: ██████████
████████████████████

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
- National Correct Coding Initiative

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 104-94
- Claims Administrator down coded ML 104 to ML 103 indicating on the Explanation of Review “Report does not meet 4 or more complexity factors listed under ML 104 as required by Title 8 CCR 9795”
- ML 103: 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; (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: (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.
- Page 1 of Provider’s Agreed Medical Examination report states “3 complexity factors for 6 or more hours were spent in the Record Review by the physician, Medical Research by the physician, and Face-to-Face Time by the physician with the injured worker which counts as 3 complexity factors. AND 1 complexity factor as this report addresses the issue of medical Causation AND 1 complexity factor as this report addresses the issue of Apportionment. 5 Total Complexity Factors. Time Spent: 30 minutes Face-to-Face Time by the physician with the injured worker. 11 hours 45 minutes Record Review by the physician. The submitted records measure greater than 4 inches in thickness. 15 minutes of Medical Research by the physician. 12 hour 30 minutes Total Time Spent”
- As mentioned in the complexity factor (3) Medical Research: An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed. No citations to any sources were documented and therefore Medical Research is not considered a factor in this review.
- Documented in Provider’s report are Causation and Apportionment each as 1 complexity factor to add to factor (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. A total of 4 complexity factors are addressed in this ML report to qualify as a level ML 104.
- Letter dated 2/10/2015 sent to Provider to evaluate the injured worker as an Agreed Medical Examiner.
- Based on information reviewed, additional reimbursement is warranted as ML 104-94.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104-94

Date of Service: 03/02/2015					
Medical Legal Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
ML 104	\$3906.25	\$1171.88	\$2760.43	\$3828.13	DISPUTED SERVICE: Allow reimbursement \$2656.25

Copy to:

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