

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 27, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001645	Date of Injury:	05/07/2014
Claim Number:	[REDACTED]	Application Received:	09/18/2015
Assignment Date:	10/19/215		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/20/2014 – 11/20/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML103		

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,

Paul Manchester, M.D., M.P.H.  
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 Official Medical 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 seeking remuneration for ML104 services performed on 11/20/2014.**
- The Claims Administrator down-coded ML104 services to ML103 based elements of exam.
- Authorization from Legal Parties to Provider confirms request for AME services, relating to the field of orthopedics.
- The following requests are noted on the (fax dated) 11/18/2014 Authorization:
  - Address 11 direct issues/questions/concerns including:
    - Causation
    - Apportionment
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...” MI104 (3)(i) (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: relevant the records, **face-to-face time** with the injured worker, preparing the report and, if applicable, any other activities.
- Med Legal OMFS ML104 criteria when compared to abstracted information provided on the AME report revealed the following:

1. Two or more hours of face-to-face time by the physician with the injured worker. **Unable to Determine** – Report Reflects “eight hours and thirty minutes in face to face time **and** in review of medical records.” **Actual Face-to-Face time is unclear. Criteria Not Met.**
2. Two or more hours of record review by the physician **Unable to Determine** – Report Reflects “eight hours and thirty minutes in face to face time **and** in review of medical records.” **Actual Record Review3 time is unclear.**
3. Two or more hours of medical research by the physician. Not Indicated – Criteria Not Met
4. Four or more hours spent on any combination of **two** 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. 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 Met.**
7. Addressing the issue of Apportionment under the following circumstances: **Criteria Not Met. Page 12** of AME Report the Provider indicates Apportionment deferred and “will be addressed once his condition has reached Maximal Medial Improvement.”
  - LC § 4663 (c) In order for a physician's report to be considered complete on the issue of permanent disability, **the report must include an apportionment determination.** A physician shall make an apportionment determination by finding what **approximate percentage** of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries. If the physician is unable to include an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to make the final determination.
8. 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. Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met.**
  - ML104 (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
  - Criteria Not Met for ML104 Services.
  - **Based on the aforementioned documentation and guidelines, additional reimbursement for ML104 is not indicated.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: ML104**

<b>Date of Service:</b> 11/20/2014							
<b>Med Legal Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML104	\$3,812.50	\$0.00	\$3,812.50	N/A	61	\$3,625.00	Med Legal OMFS
96101	\$474.35	\$0.00	\$473.35	N/A	4.5	\$379.48	Med. Legal OMFS

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]