

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 30, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001802	Date of Injury:	10/20/2013
Claim Number:	[Redacted]	Application Received:	10/05/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	07/06/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-94		

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, 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
- Negotiated contracted rates: N/A
- National Correct Coding Initiatives

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 ML 104-94
- Claims Administrator reimbursed \$1171.88 for an ML 103-94 indicating that Apportionment was not addressed in the Provider's report.
- Page 16 of Provider's report documents "Review of multiple medical records; Apportionment is addressed; Medical causation is addressed; 20 minutes face-to-face time; 4 hours review of records time; 3 hours and 45 minutes report preparation time including medical research"
- § 9795. Reasonable Level of Fees for Medical-Legal Expenses: The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.
- ML 103 - (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(**An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed**); (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; 6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report; (7) Addressing the issue of apportionment,

- Abstracted from Provider’s report: face-to-face time, record review and causation to count as three (3) determining factors for the level of service.
- Apportionment is the process in which an overall permanent disability that was caused at least in part by an industrial injury is separated into the components that are and are not compensable results of that injury. This was not addressed in the Provider’s report and therefore, Apportionment is not considered a factor in determining the level of service for date of service 7/6/2015.
- Based on information reviewed and guidelines, additional reimbursement of ML 104-94 is not warranted.

The table below describes the pertinent claim line information.

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

Date of Service: 07/06/2015						
Medical Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
ML 104 as ML 103	\$2,790.50	\$1,305.26	\$1,485.24	1	\$1171.88	No further reimbursement recommended

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