

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 13, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001911	Date of Injury:	06/13/2014
Claim Number:	[Redacted]	Application Received:	10/16/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	07/09/2015		
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: 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 on date of service 7/9/2015.
- Claims Administrator down coded to ML 103 indicating on the Explanation of Review “Report does not meet 4 or more complexity factors listed under ML104 as required by Title 8 CCR 9795”
- Provider was requested as a Qualified Medical Examiner for date of service 7/9/2015.
- Provider’s report submitted states an ML 104 and meets four complexity factors to include: “1. (5) 6+ hours spent on any combination of three of the complexity factors (1)-(3), which shall count as three complexity factors: 2. (6) Addressing the issue of medical causation, which shall count as one complexity factor; 3. (7) Addressing the issue of apportionment, which shall count as one complexity factor;”
- 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.**
- Provider’s report does not document the medical research description as required for complexity factor (5) as stated. Therefore, medical research cannot be counted for this review.

- Request for QME from Attorney **specifically** asks for Provider “Did the applicant sustain an injury arising out of and occurring in the scope of her employment? If so, what is the diagnoses, and date of injury?”
- Under Causation in report submitted, states “AOE – COE injury from work. AOE – COE impairment from work.”
- As Provider did not fulfill the request for Causation, Causation cannot be counted as one of the complexity factors for this medical legal.
- Abstracted from the Provider’s report includes: (4) four or more hours spent on any combination of two of the complexity factors (1)-(3) which shall count as two complexity factors; and Apportionment which shall count as one complexity factor.
- Medical Legal report submitted qualifies as an ML 103 which Claims Administrator reimbursed Provider as.
- Based on aforementioned documentation and guidelines, no further reimbursement is recommended for this medical legal.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104

Date of Service: 07/09/2015					
Medical Legal					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
ML 103	\$4500.00	\$937.50	\$3,562.50	\$937.50	Refer to Analysis

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