

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 14, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000918	Date of Injury:	09/06/2011
Claim Number:	[Redacted]	Application Received:	06/08/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	11/24/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104		

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:
- National Correct Coding Initiatives
- Other: 9795 Reasonable Level of Fees for Medical Legal Expenses

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
- Claims administrator reimbursed \$1000 indicating on the Explanation of Review “The charge for the procedure exceeds the amount indicated on the fee schedule”
- 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.
- 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; (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;
- Provider’s report submitted documents “Time spent in face-to-face with the patient was 1 hour. Time spent reviewing records was 35 hours 30 minutes. Time spent preparing the

report was 3 hours 30 minutes. Total time spent on this case was 40 hours.” Provider also documents addressing the issue of medical causation.

- Provider documents (5) as three complexity factors were met. However, medical research was not documented in Provider’s report and therefore, (5) is not valid, however (4) is valid for 2 complexity factors. Plus Causation for a total of 3 complexity factors met for this report qualifying this Medical Legal as ML 103.
- Based on information reviewed, no further reimbursement is warranted for ML 104.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104 as ML 103

Date of Service: 11/24/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
ML 103	\$10000.00	\$1000.00	\$9000.00	160	N/A	\$937.50	DISPUTED SERVICE: No further reimbursement is recommended

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