

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 12, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0002292	Date of Injury:	05/22/2014
Claim Number:	[Redacted]	Application Received:	12/17/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/30/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-93		

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
- 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 performed on 03/30/2015
- Claims Administrator down-coded ML 104 to Ml 103 with rationale “The report does not meet the four complexity factor criteria required to bill under code ML104.”
- **ML 103: *Complex Comprehensive Medical-Legal Evaluation*.** Includes evaluations which require three of the complexity factors set forth below. 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**
- Evaluation Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:
 - **(1) Two or more hours of face-to-face** time by the physician with the injured worker; 4 hours and 15 minutes
 - **(2) Two or more hours of record review** by the physician; 8 hours
 - **(3) Two or more hours of medical research** by the physician; **Not Met**
 - **(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; **Criteria Met – Provider documents 4 hours and 15 minutes face-to-face with the patient and 8 hours of record review**

- (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; **Not Requested.**
 - (7) **Addressing the issue of apportionment: Criteria Met**
 - (8) **A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. Criteria Not Met**
 - (9) **Where the evaluation is performed for injuries that occurred before January 1, 2013**, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician on or before June 30 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **N/A**
- Three (3) complexity factors are supported by Provider’s report.
 - **ML 104 Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances:**
 - (1) An evaluation which requires four or more of the complexity factors listed under ML 103: **Not Met**
 - (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: **Not Met**
 - (3) A comprehensive medical-legal evaluation for which the physician and the parties agree, **prior to the evaluation**, that the evaluation involves extraordinary circumstances: **Not Met**
 - Modifier -93: Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML 102 and ML 103.
 - Pursuant §9795, report submitted does not qualify as ML 104, however, report does qualify as ML 103. Claims Administrator reimbursed Provider for the ML 103 with increased value of modifier -93. Therefore, no further reimbursement recommended for ML 103-93.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 103-93.

Date of Service: 03/30/2015					
Medical Legal Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
ML 103	\$7,012.50	\$1,031.25	\$5,981.25	\$1,031.25	Refer to Analysis

Copy to:

[REDACTED]

[REDACTED]