

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 31, 2016

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB16-0000376	Date of Injury:	04/26/2015
Claim Number:	[Redacted]	Application Received:	03/03/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	10/20/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-95* IBR amended 03/22/2016 removing codes 72114 and 72020 x 4 from the request. The amount in dispute is now \$5875.00		

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$5,875.00 in additional reimbursement for a total of \$6,070.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$6,070.00 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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

[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 OMFS

## 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 ML104-95 submitted for date of service 10/20/2015.**
- The Claims Administrator denied service based on “Claim denied because this is not a work related injury/illness and thus not the liability of the workers’ compensation carrier.”
- **CCR § 4620. (a)** A medical-legal expense means **any costs** and expenses incurred by or on behalf of any party, the administrative director, or the board, which expenses may include X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and, as needed, interpreter's fees by a certified interpreter pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code, for the purpose of proving or disproving a contested claim.
- **Copy of the Original QME exam request from legal party dated September 17, 2015 was submitted for review and verification.**
- **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.

- The first paragraph of the Provider’s report documents “3.75 hours of face-to-face time, 1 hour spent on research, 7.25 hours of record review, and an additional 12.25 hours spent writing this report. Causation and apportionment were discussed”
- Page 41 of Provider’s report documents Causation and Apportionment. Page 42-43 documents sources reviewed for medical research.
- **Based on the aforementioned documentation and guidelines, criteria was met for ML104-95 services.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: ML104-95**

Date of Service: 10/20/2015						
Med-Legal						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
ML104-95	\$5,875.00	\$0.00	\$5,875.00	94	\$5,875.00	<b>\$5,875.00 Due to Provider</b>

[REDACTED]  
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