Dear [Name]:

**Determination:**
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/30/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the Claims Administrator’s determination is upheld. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**
The following evidence was used to support the decision:
- 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
Supporting Analysis:
The dispute regards the payment amount for Medical-Legal services (ML103 Modifier 93 and 95) for date of service 4/11/2013. The Claims Administrator based its reimbursement of ML103 on ML101 with the explanation of "Reimbursement of code ml103 is not recommended as neither billing nor report substantiates that level of service as defined in CCR 9795."

ML101 - Follow-up Medical-Legal Evaluation. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour.

The description of Medical-Legal code ML103 is "Complex comprehensive Medical-Legal evaluation."
The criteria for ML103 requires three of the ten complexity factors to be met and documented by the Provider.
The description of the ten complexity factors listed in Medical-Legal code ML103 are as follows:
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 complexity factors (1-3), which shall count as two complexity factors.
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, or if a bonafide issue of medical causation is discovered in the evaluation.
7. Addressing the issue of apportionment, when determining this issue requires the physician to evaluate the claimant’s employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
8. Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances.
9. A psychiatric or psychological evaluation which is the primary focus of the Medical-Legal evaluation.
10. Addressing the issue of denial or modification of treatment by the Claims Administrator following utilization review under Labor Code section 4610.

The description of Modifier 93 is "Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increases 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."
The description of Modifier 95 is "Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure."

The Provider indicated at the beginning of the Medical-Legal report a total of three complexity factors were met: two hours of record review; causation; and apportionment. The provider documented two hours of record review time, which met the criteria of complexity factor one. The medical legal evaluation request from the Claims Administrator requested causation to be addressed in the medical legal report. The causation complexity factor was met and counts as one factor. The complexity factor of apportionment was not met. The evaluation and apportionment determination was based on one injury to one body region (left shoulder). Based on a review of the Medical-Legal report, a total of two of the ten complexity factors were met. The Medical-Legal evaluation request letter from the Claims Administrator indicated the evaluation was a "re-exam" and the initial visit was on 7/12/2012. The re-evaluation on 4/11/2013 was within nine months of the initial evaluation. The reimbursement of ML101 by the Claims Administrator was correct.

The Claims Administrator reimbursed the Provider $687.50, which included the allowance for ML101 and Modifier 93. There is no additional reimbursement warranted per the Medical-Legal code ML101.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Units</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>ML101</td>
<td>1</td>
<td>$343.75</td>
<td>$625.00</td>
<td>$687.50</td>
<td>$0.00</td>
<td>OMFS</td>
</tr>
</tbody>
</table>

**Chief Coding Specialist Decision Rationale:**
This decision was based on Medical-Legal Fee Schedule, medical record and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $687.50 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)
Sincerely,

[Redacted]

Copy to:

[Redacted]

Copy to:

[Redacted]