

MAXIMUS FEDERAL SERVICES, INC.

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

Independent Bill Review Medical/Legal Final Determination Upheld

12/12/2013

██████████
██████████
██████████

Re: Claim Number: ██████████
Claims Administrator name: ██████████
Date of Disputed Services: 5/3/2013 – 5/3/2013
MAXIMUS IBR Case: CB13-0000326

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/30/2013, 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
- Medical Legal Fee Schedule in effect July 1st, 2006

Supporting Analysis:

The dispute regards the payment amount for Med-Legal services (ML104 Modifier 95) for date of service 5/3/2013. The Provider billed ML104 Modifier 95, was reimbursed \$937.50 and is requesting additional reimbursement of \$1,562.50. The Claims Administrator based its reimbursement of ML104 Modifier 95 on ML 103 indicating "Based on the documentation the following factors were met for determining the level of reimbursement: #4 and #6; However, per the ML FS the following were not considered factors or were not met: #5 & #7."

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 description of Medical-Legal code ML104 is " Comprehensive Medical-Legal evaluation involving extraordinary circumstances." The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:

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.
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, including three or more hours of record review by the physician;
3. A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

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 Medical-Legal report submitted by the Provider did not meet the required four complexity factors of ML104. The provider documented eight hours of record review time and sixty minutes of face to face time, which met the criteria of complexity factor four. The complexity factor four counts as two complexity factors. The complexity factor of apportionment was not met. Per the Claims Administrator's explanation of review, the causation factor was met. Based on the documentation submitted, only three of the ten complexity factors were met.

The other requirements described in the definition of ML104 were not met according to the documentation submitted. The Provider did not indicate that the evaluation involved extraordinary circumstances or an agreement between the parties indicating that the services billed would be considered as a ML104. Therefore, the medical record did not support the reimbursement of ML104.

Based on the documentation submitted, additional allowance for the disputed code is not warranted. The code assignment of Medical-Legal code ML103 by the Claims Administrator was correct.

There is no additional reimbursement warranted per Official Medical Fee Schedule code ML103 Modifier 95.

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ML103	95	1	\$1,562.50	\$937.50	\$937.50	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on Medical-Legal Fee Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$937.50 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,

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