

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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11/14/2013

Independent Bill Review Medical/Legal Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/29/2013 – 3/29/2013
MAXIMUS IBR Case: CB13-0000327

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/26/2013, 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 amount paid for Medical-Legal services on date of service 3/29/13. The Provider billed Medical-Legal code ML104 Modifier 93 and 95, was reimbursed \$937.50 and is requesting an additional payment of \$1,187.50. The Claims Administrator based its reimbursement of billed code ML104 on ML103 indicating "Based on the documentation the following factors were met for determining the level of reimbursement: R/R, F2F, causation. However, per the ML FS the following are not considered factors are were not met: apportionment."

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 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."

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 criteria for ML104 requires four or more of the ten complexity factors listed under ML103 to be met and documented by the Provider.

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 seven 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. The report documented an evaluation or discussion of one injury to one body system or region (right shoulder and wrist). 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 report documented the presence of the interpreter only and did not include a description or documentation of the additional time required for the examination as a direct result of the use of an interpreter. The denial of Modifier 93 by the Claims Administrator was correct.

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.

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 Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ML103	95	93	1	\$1,187.50	\$937.50	\$937.50	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS 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,

[REDACTED], RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
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