

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

9/24/2014

████████████████████
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IBR Case Number:	CB13-0000554	Date of Injury:	01/22/2013
Claim Number:	██████████	Application Received:	10/02/2013
Claims Administrator:	██		
Date(s) of service:	06/21/2013 – 07/11/2013		
Provider Name:	██		
Employee Name:	████████████████████		
Disputed Codes:	ML104, 99080		

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/24/2014, 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
- Other: Med. Legal. OMLFS

Supporting Analysis:

Pursuant to Title 8 California Code of Regulations Sections 9793 & 9795, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Legal Fee Schedule as the Basis for billing and payment of Medical Legal Services provided for injured employees under the Workers' Compensation Laws of California.

The dispute regards Medical Legal Service charges for date of service 06/21/2013. The Provider is a Qualified Medical Examiner who agreed to conduct a medical legal evaluation on an injured worker for the Claims Administrator. Submitted charges from the Provider included an ML104 evaluation and a 99080 Special Report code; billed to the Claims Administrator for a total of \$2,517.50. The Claims Administrator denied the codes for the following reasons:

1. **ML104:** Based on the documentation the following factors were met for determining the level of reimbursement: #6. However, per the ML FS the following are not considered factors or were not met, #1, 2, 3, 4, 7, 8, 9, 10
2. **99080:** No separate payment was made because the value of the service is included within the value of another service performed on the same day.

ML104 was down-coded by the Claims Administrator to ML102 and the Provider was reimbursed \$625.00 for this service.

ML 102 is defined as follows by the State of California Workmans' Compensation Official Medical Legal Fee Schedule (OMLFS):

ML 102 - RV 50 Per Evaluation \$625.00

- A basic medical evaluation which does not meet the criteria of any other medical-legal evaluation.
- Paid at a flat rate.
- All expenses are included except for diagnostic testing.

The Official Medical Fee Schedule defines the procedure code in question as follows:

CPT 99080: Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. Also to be used for separately reimbursable reports.

The Provider is seeking full remuneration for ML104 and 99080.

The California Workmans' Compensation Medical Legal Fee Schedule determines the level of a Medical Legal Evaluation with the following Complexity Factors:

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.
 - Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor.

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 bona fide issue of medical causation is discovered in the evaluation.
7. Addressing the issue of Apportionment under the following circumstances:
 - when determination of this issue requires the physician to evaluate three or more injuries or pathologies.
 - 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)
 - two or more or more injuries involving two or more body systems or body regions as delineated in the above mentioned Table of Contents. upon written request of the party or parties requesting the report
 - if a bona fide issue of apportionment is discovered in the evaluation.
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.

Additional factors for clarifying a medical-legal evaluation level according to LC § 4628, Composing and drafting the conclusions of the report include:

- Medical Research
 - is the investigation of medical issues.
 - It includes:
 - investigating and reading medical and scientific journals and texts.
 - It does not include:
 - reading or reading about the **Guides** for the Evaluation of Permanent Impairment (any edition)
 - treatment **guidelines** (including **guidelines** of the American College of Occupational and Environmental Medicine)
 - the Labor Code, regulations or publications of the DWC (including the Physicians' **Guide**)
 - other legal materials.

Upon review of the Medical Legal Report provided, the complexity of the report was analyzed and compared to Complexity Factors 1 – 10 above.

1. Two or more hour criteria not met.
 - The Provider states "face-to-face" time is "90."
2. Two or more hour criteria not met.
 - "75" minutes to "review all information forwarded."
3. Criteria Not Met
 - one source cited, source 5, falls within LC § 4628 definition of "Medical Research."
4. Criteria Not Met
 - "2 hours on Medical Research" 1 & 2 = 2 hrs. 5 min

5. Criteria Not Met, refer to #4
6. Criteria Met
 - Beginning on page 5 of the Medical Legal Report
7. Does not apply
 - refer to criteria 7 definition.
8. Does not apply
9. Does not apply
10. Criteria Not Met
 - refer to criteria “10” definition.

Given the abstracted information reviewed for ML 104, the full criteria for this Medical-Legal Service Code were not met and additional reimbursement cannot be recommended.

The final code in question is Current Procedural Code 99080. The Medical-Legal Fee Schedule states the following are included in a Medical Legal Service Code:

- The fee for each medical-legal evaluation procedure is all inclusive, and includes reimbursement for:
 - The history
 - The physical examination
 - Review of records
 - Preparation of a medical-legal report including
 - typing
 - transcription services
 - Please note: the typing and transcription services are not separately reimbursable; they are already included in the payment for the evaluation.
- Overhead expenses.

Given the guidelines for Medical Legal Service Codes, reimbursement for CPT 99080 cannot be recommended.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ML 104	1	\$2187.50	\$0.00	\$625.00	\$0.00	OMLFS
99080	1	\$330.00	\$0.00	\$0.00	\$0.00	OMLFS

Chief Coding Specialist Decision Rationale:

This decision was based on aforementioned guidelines and comparison with OMLFS. This was determined correctly by the Claims Administrator and the payment of \$625.00 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
Chief Coding Reviewer

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