

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

9/25/2014

████████████████████
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████████████████████

IBR Case Number:	CB13-0000857	Date of Injury:	11/14/2012
Claim Number:	██████████	Application Received:	12/13/2013
Claims Administrator:	██		
Date(s) of service:	09/20/2013		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	ML104 -95		

Dear ██████████

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 04/02/2014, 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 dates of service 09/20/2013. 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 a ML104 evaluation; billed to the Claims Administrator for a total of \$1,500. The Claims Administrator denied the codes for the following reasons:

1. The 'Amount not Allowed' is the amount in excess of the Work Comp Fee Schedule.
2. Time spent on report is not considered a complexity factor.
3. The 4 hours spent face-to-face with the patient and on reviewing medical records counts as only 2 complexity factors.
4. A request was not made for causation to be addressed, nor did you find an issue of causation during the evaluation.
5. This case involves a single injury to a single body part with a single employer. Therefore the use of Addressing Apportionment as a complexity factor does not apply.

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

The Provider is seeking full remuneration for ML104 and the corresponding billed charge of \$1,500.00.

Medical Legal codes utilized in the claim in question will be defined according to the State of California Workmans' Compensation Official Medical-Legal Fee Schedule (OMLFS).

ML 102 is defined as follows by the 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 OMLFS 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.
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.
 - 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.

**ML 104 - RV 5 per 15 Min.
\$62.50/15 min or \$250/Hr**

- **4 or more complexity factors**
 - 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.
- 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.
- 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:

- a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code
- 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
 - If applicable, any other activities.

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 “30” min
2. Two or more hour criteria not met.
 - The Provider states “3 1/2” hours
3. Complexity Criteria Not met.
4. Complexity Criteria Met
 - Refer to 1 & 3 (**2 factors**)
5. Complexity Criteria Not Met
6. Criteria Not Met
 - Formal Request for Causation Not Supplied with IBR documentation.
7. Criteria Not Met
 - Only two injuries to same body part.
8. Does Not apply
9. Does Not apply
10. Criteria Not Met
 - Refer to criteria “10” definition.

The documented complexity factor of **2** falls within the guidelines of ML 102. Given the abstracted information reviewed for ML 104, and the authorization for services dated 07/30/2013, the full criteria for this Medical-Legal Service Code were not met and additional reimbursement 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	\$1,500.00	\$0.00	\$0.00	\$0.00	OMLFS
ML 102	1	\$1,500.00	\$625.00	\$625.00	\$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,

██████████, RHIT
Chief Coding Reviewer

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