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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 12, 2014

[redacted]

IBR Case Number:	CB14-0000989	**Date of Injury:**	1/25/2002
Claim Number:	[redacted]	**Application Received:**	7/9/2014
Claims Administrator:	[redacted]	**Assignment Date:**	8/13/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	ML104-94		

Dear [redacted]:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above workers' compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $7,342.00 in additional reimbursement for a total of $7,592.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $7,592.00 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[redacted]
Medical Director

cc: [redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- Med Legal Official Medical Fee Schedule

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE**: Provider disputing Med-Legal ML104-94 reimbursement for services performed on 05/20/2013.
- Claims Administrator reimbursement rational: "Payment based on pre-negotiated agreement for this specific service," and "Reimbursement of $3500.00 per adjusters authorization."
- Authorization, dated May 3, 2013 for Med-Legal services addressed to the Provider, from the Claims "Adjuster," requesting "AME" evaluation regarding the following issues: a) Permanent and stationary status b) The extent and scope of medical treatment & c) the level of permanent disability
- May 3, 2013 AME Evaluation Authorization did not reference a contractual agreement /pre-negotiated rate, between the Provider and Claims Administrator for Med-Legal services.
- Letter to IBR dated August 7, 2014 from the Claims Administrator stated the payment for Med-Legal service "should have came (come) from… with a specific negotiated rate."
- As noted, there is a finding of an agreement of a negotiated rate in the documentation presented for IBR.
- Authorization for a Med Legal service not in dispute as the Claims Administrator reimbursed the Provider $3,500.00 for ML104 services. In absence of a Contractual Agreement, IBR must proceed and evaluate and verify the level of service performed as dictated by Article 5.6 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations.

- It appears the Claims Administrator reimbursed the Provider for 56 units of ML104. In absence of a pre-negotiated contractual rate for this accepted ML104 service, the time factor for ML104 services will be reviewed.
- **Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:**
  (1) **2** or more hours Face-to-Face time – **Criteria Met**, Provider States "**2 Hours**."
  (2) 2 or more hours Record Review – **Criteria Met,** Provider states, "**27.5 Hours**."
  (3) Two or more hours of medical research by the physician;
  Med. Legal OMFS, "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" **Criteria Met –** Cited non- guideline related sources located in footnotes on page 105 of the AME report in accordance with §9793 5 j of Article 5.6, provider states, "**2 Hours**."
  (4)"Four or more hours spent on any combination of two of the 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."
  Criteria Met
  (5) "**Six or more** hours spent on any combination **of three** complexity factors **(1)-(3),** which shall count as **three complexity factors**." **Criteria Met**
  (6) Causation – "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. **Criteria Met -** Causation request can be found on page 2 of the Authorization for Med-Legal services; addressed on page 104 -107 of QME report.
  (7) Apportionment – **Criteria Not Met,** Provider indicates, "Only when the claimant is determined permanent and stationary can apportionment then be determined."
  (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances; **Criteria Not Met.**
  (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Not Met**
  (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. Date of QME 5/20/2014. **Criteria Not Met**,
- **Four (4)** Complexity Factor Abstracted From QME Report.
- **Criteria Met for ML104 service.**
- **Modifier -94: AME Evaluation**, Increases fee by 25%.
- **Time Factors:**
  - Face to Face: 2 Hours = 68 Units
  - Record Review: 27.5 Hours = 110 Units
  - Research: 2 Hours = 8 Units
  - Report Prep: 3.25 Hours 13 Units
  - Total Units: 139 Units (34.75 Hours) = $8,687.50
  - Modifier -94 @ 25% increase = $2,171.00
  - Provider Charged $10,842.00
  - Signed Attestation signed by Provider, Page 108 of 108, signed June 13, 2013.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for ML104-94.

Date of Service: 05/20/2013							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
ML104-94	$10,842.00	$3,500.00	$7,342.00	N/A	139	$10,842.00	**$10,842.00 (-) Reimbursement = $7,342.00 Due Provider**

Copy to:

[redacted]

Copy to:

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