

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 5, 2015

[Redacted]

IBR Case Number:	CB14-0001862	Date of Injury:	03/05/2013
Claim Number:	[Redacted]	Application Received:	12/03/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	01/28/2014 – 01/28/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML-104-94-95		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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,

Paul Manchester, MD, MPH
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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations, CCR

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 is dissatisfied with reimbursement of Medical Legal code ML 104-94-95
- Claims administrator reimbursed \$937.50 indicating on the Explanation of Review “Based on the documentation the following factors were met for determining the level of reimbursement: R/R, combined R/R and F/F. causation however per the ML FS the following are not considered factors or were not met: apportionment.”
- ML 104 - *Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances*. (1) An evaluation which requires four or more of the complexity factors listed under ML 103.
- ML 103 - *Complex Comprehensive Medical-Legal Evaluation*. Includes evaluations which require three of the complexity factors set forth below: In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following 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:** 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 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; (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; (7) Addressing the issue of apportionment

- "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" 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 Division of Workers' Compensation (including the Physicians' Guide), or other legal materials.
- Provider documents on the IBR application: ██████ said they needed a breakdown of the total time spent... which was addressed in the report (page 2). ██████ addressed causation under the "Conclusion" header, as requested in the cover letter (= 1 complexity factor). ██████ also had 14 hours in total time (lines 1-3. over 6 hours on ANY combination = 3 complexity factors). The clmt had prior multiple injuries & required over 3 hours of Medical Record review (= 1 complexity factor). On provider's PQME report, page 2, he documents "A total of 14 hours were spent on this case, including 1 hour and 15 minutes to conduct the claimant's Orthopedic physical examination and obtaining a detailed claimant history, 8 hours and 45 minutes for review of medical records made available and 4 hours for analysis, medical research and report preparation which included addressing causation and apportionment."
- Provider's report reviewed does indeed state face-to-face time with injured worker and medical record review. However, medical research is not indicated as per the Medical Legal requirement of 'Medical Research' Section §9795. Both Causation and Apportionment were requested by the attorney per Panel QME Cover Letter dated January 8, 2014 submitted for this review. Provider briefly mentions Causation in his Conclusion statement which does not satisfy the Medical Legal Regulation of ML 103 (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report. A separate portion of the report needs to specify Causation separately as well as Apportionment.
- Provider also billed modifier -94: Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. Per Panel QME Cover Letter submitted, the request for the provider is a panel QME, not AME. Therefore, the billing for modifier -94 was unjustified and therefore requires no reimbursement.
- Based on information reviewed, additional reimbursement of ML 104-94-95 is not warranted

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code ML 104-94-95 is not recommended.

Date of Service: 1/28/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 104-94-95	\$4375.01	\$937.50	\$3437.51	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

Copy to:

[REDACTED]
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