

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 7, 2015

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000205	Date of Injury:	05/15/2012
Claim Number:	[REDACTED]	Application Received:	02/13/2015
Claims Administrator:	[REDACTED]	Assignment Date:	03/12/2015
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-95-25, 95851-59 x 2, 95851-59-RT, 95851-95-LT, 95832-59, 72100, 72040, 73030-RT and 73030-LT		

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 \$195.00 for the review cost and \$1,164.82 in additional reimbursement for a total of \$1,359.82. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,359.82 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,

Paul Manchester, M.D., M.P.H.
Medical Director

cc: [REDACTED]
[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
- AMA CTP 2014
- 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 seeking remuneration for ML104-95-25, 95851-59 x 2, 95851-59-RT, 95851-95-LT, 95832-59, 72100, 72040, 73030-RT and 73030-LT services performed on 07/26/2015.**
- Claims Administrator reimbursed \$0.00 of \$3,717.33 with the following rationale: “Carrier not liable for claim/service treatment.”
- Authorization for “**State Panel Qualified Medical Evaluator**,” services, dated July 10, 2014, signed by the Legal Parties, addressed to the Panel Qualified Medical Examiner (Provider) reflects authorization for Med-Legal Services.
- The following requests are noted on the July 10th, 2014 Authorization:
 - Medical Exam
 - Detailed History
 - Perform any non-invasive testing Provider deems “necessary”
 - Address 14 direct issues/questions/concerns
 - Causation
 - Apportionment

- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- Med Legal OMFS ML104 criteria when compared to abstracted information provided on the **Fee Disclosure** and **QME Report** revealed the following:
 1. Two or more hours of face-to-face time by the physician with the injured worker. **“90” min, Criteria Not Met**
 2. Two or more hours of record review by the physician **“8.0” hours Criteria Met**
 3. Two or more hours of medical research by the physician. **Criteria Not Met**
 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. **Criteria Not Met**
 5. Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors. **Criteria Not Met**
 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. **Criteria Met, page 19 of QME Report.**
 7. Addressing the issue of Apportionment under the following circumstances: **Criteria Met - Percentage of Apportionment Indicated, Page 20 of QME Report.**
 8. 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. Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met.**
- **Criteria Not Met for ML104.**
- **Criteria Met for ML103:** A basic medical evaluation which involves three complexity factors. Paid at a flat rate. **All expenses are included except for diagnostic testing.**
- QME report indicates the following TC & PC component of the following x-rays were formed at the Provider’s Office:
 - ✓ Cervical Spine, X-ray exam neck spine 2-3 views (CPT 72040)
 - ✓ Left Shoulder, X-ray exam of shoulder (CPT 73030)
 - ✓ Right Shoulder, X-ray exam of shoulder (CPT 73030)
 - ✓ Lumbar Spine, X-ray exam l/s spine (CPT 72100)
- **CPT 95851** Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine) **& CPT 95832** Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side, in accordance with ML103 code description is not separately reimbursable.
- **Based on the aforementioned documentation and guidelines, reimbursement is recommended for ML103-95, CPT 72100, 7204.30-RT and 73030-LT.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104-95-25, 95851-59 x 2, 95851-59-RT, 95851-95-LT, 95832-59, 72100, 72040, 73030-RT and 73030-LT

Date of Service: 07/26/2014							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$3,375.00	\$0.00	\$3,375.00	N/A	54	\$937.50	Reimburse as ML103 Refer to Analysis
95851-59	\$21.33	\$0.00	\$21.33	N/A	2	\$0.00	Refer to Analysis
95851-59-RT	\$21.33	\$0.00	\$21.33	N/A	1	\$0.00	Refer to Analysis
95851-95-LT	\$21.33	\$0.00	\$21.33	N/A	1	\$0.00	Refer to Analysis
95832-59	\$21.33	\$0.00	\$21.33	N/A	2	\$0.00	Refer to Analysis
72100	\$61.02	\$0.00	\$61.02	N/A	1	\$61.02	Refer to Analysis
72040	\$61.02	\$0.00	\$61.02	N/A	1	\$61.02	Refer to Analysis
73030-RT	\$52.64	\$0.00	\$52.64	N/A	1	\$52.64	Refer to Analysis
73030-LT	\$52.64	\$0.00	\$52.64	N/A	1	\$52.64	Refer to Analysis

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