MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 1, 2015

[redacted]

IBR Case Number:	CB15-0001488	Date of Injury:	05/25/2013
Claim Number:	[redacted]	Application Received:	08/31/2015
Assignment Date:	09/17/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	04/27/2015 – 04/27/2015		
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: 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, M.D., M.P.H.
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 OMFS

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 additional remuneration for billed Med-Legal ML104-94 services, date of service 04/27/2015.**
- Claims Administrator denied reimbursement for services with the following rational: "complexity factors."
- **CCR § 9795.** Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony. **(c)** Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows: **ML104** Procedure Description: A comprehensive medical-legal evaluation for which **the physician and the parties agree**, **prior to the evaluation**, **that the evaluation involves extraordinary circumstances.**
- Med Legal OMFS Modifier -94, increases fee by 25%.
- **Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement (Page 15 AMA Report):**
  - (1) **2 or more hours** Face-to-Face time – **Criteria Not Met**, Provider States "20 minutes"
  - (2) 2 or more hours Record Review – **<u>Criteria Met</u>,** Provider states, "5 hours 30 min."
  - (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 Not Met –** in accordance with **§ 9793 (j):** "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.

- (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 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) 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**
- (7) Apportionment – **Criteria Not Met**
  - **Labor Code § 4663** (c) A physician shall make an apportionment determination by finding **what approximate percentage** of the permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries.
  - Page 4 and an unnumbered page, entitled "Review of Records," entered after paragraph entitled, "Causation," the Provider indicates "Apportionment needs to be discussed at the time of maximum medical improvement, as appropriate." The **percentage** requirement per LC § 4663, has not been met.
- (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 04/27/2015. **Criteria Not Met**

- **Two (2) Complexity Factors abstracted from AME Report. Criteria not met for ML104.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional remuneration for ML104-94 is not indicated.

Date of Service: 04/27/2015							
Med-Legal Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
ML104 -94	$3,168.25	$1,350.95	$0.00	N/A	1	$1,350.95	**Refer to Analysis**

Copy to:

[redacted]

Copy to:

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