

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 3, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000736	Date of Injury:	08/28/2010
Claim Number:	[Redacted]	Application Received:	05/08/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	11/25/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-94-95-93		

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 \$1937.50 in additional reimbursement for a total of \$2132.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2132.50 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, MD, MPH
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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Medical Legal 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 is dissatisfied with denial of ML 104-94-95-93
- Claims Administrator denied payment on ML 104-94-95-93 indicating on the Explanation of Review “The appended modifier code is not appropriate with the service billed”
- Provider was requested to perform an evaluation on the injured worker as a Qualified Medical Evaluator per letters submitted dated November 5, 2014 and a second letter dated November 11, 2014. Therefore, modifier -94 is not appropriate to bill with this medical legal service.
- As of January 1, 2014 reimbursement for modifier -93 no longer exists. Therefore, increased reimbursement is not warranted for modifier -93.
- ML 103: Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth. **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, when determination of this issue requires the physician to evaluate 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), or two or more or more injuries involving two or more body systems or body regions as delineated in that 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) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. (9) Where the evaluation is performed for injuries that occurred before January 1, 2013, concerning a dispute over a utilization review decision if the decision is communicated to the requesting physician 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.

- Provider billed ML 104 and documents: “Combined time spent in face-to-face evaluation (1 hour), review of all current and past information (3 hours 15 minutes), physician dictation and editing time spent in the preparation of the report (3 ½ hours), and Addressing issues of causation and apportionment as requested”
- As report preparation is not considered as one of the complexity factors, Provider does discuss Causation and Apportionment which qualifies as an ML 104-95.
- Based on information reviewed, reimbursement of ML 104 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104

Date of Service: 11/25/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 104-95	\$2523.68	\$0.00	\$2523.68	31	N/A	\$1937.50	DISPUTED SERVICE: Allow reimbursement \$1937.50

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
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