

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 2, 2016

██████████
████████████████████
████████████████████

IBR Case Number:	CB16-0000015	Date of Injury:	02/27/2014
Claim Number:	██████████	Application Received:	01/05/2016
Assignment Date:	01/22/2015		
Claims Administrator:	████████████████████		
Date(s) of service:	10/27/2015 – 10/27/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	ML104		

Dear ██████████:

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 \$189.34 in additional reimbursement for a total of \$384.34. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$384.34** 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: ██████████
████████████████████████████████████████

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 remuneration for ML104 services submitted for date of service 10/27/2015.**
- The Claims Administrator re-assigned ML104 to 99205, New Patient Evaluation and WC004 Permanent and Stationary Report.
- Authorization signed by Claims Administrator on September 15, 2014 reflects request for a medical examination relating to Injured Worker's right ankle; directives, including causation, and apportionment are reflected in the authorization.
 - Authorization indicates Med-Legal exam involving extraordinary circumstances to include causation and apportionment of possible permanent and stationary status.
- QME Report indicates Injured Worker is not yet "Permanent and Stationary," the code reassignment WC004 is incorrect.
- Authorization clearly indicates a Med-Legal examination was requested of the Provider. The Code Reassignment 99205, is not a valid code for a Med-Legal Evaluation.
- **Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:**
 - (1) 2 or more hours Face-to-Face time – **Criteria Not Met**, Page 02, Paragraph 2 of QME Report, the Provider States **"1 hour face-to face with applicant."**
 - (2) 2 or more hours Record Review – **Criteria Not Met**, Page 07 of QME Report the provider indicates records were "summarized for (Provider's) review; staff time may not be included in The QME's reported record review time."
 - **§ 9793 (c)** "Comprehensive medical-legal evaluation" means an evaluation of an employee which (A) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (B) is either:
 - (1) **performed by a Qualified Medical Evaluator** pursuant to subdivision (h) of Section 139.2 of the Labor Code, or
 - (2) **performed by a Qualified Medical Evaluator**, Agreed Medical Evaluator, or the primary treating physician for the purpose of proving or disproving a contested claim, and which meets the requirements of paragraphs (1) through (5), inclusive, of subdivision (g).
 - **ML104 (3)** When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) **verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.**
 - (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." **The "Appendix," page 13 of QME Report Indicate ODC (Official Disability Guidelines ankle, pain and radiology chapters).**

- (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**
 - **Noted** page 5, under the heading "Grip Strength the AMA guidelines are referenced. However, no other references cited on the 'Appendix' can be located within the body of the QME report.
- (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 page 2 of QME Request.**
- (7) Apportionment – **Criteria Not Met. Page 11 of QME Report**, under the heading "AMA Impairment Rating," the Provider indicates, "The applicant has not yet reached maximum medical improvement." Apportionment of disability only applies to permanent disability.
- (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 - Provider is a QME Orthopedic Surgeon.**
- (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. **Criteria Not Met, Date of QME 10/27/2015.**
- **One (1) Complexity Factors Abstracted From QME Report.**
- **Criteria not met for ML104, recommend reimbursement for documented service ML102.**
- **ML102 - A basic medical evaluation which does not meet the criteria of any other medical-legal evaluation.**
 - Paid at a flat rate.
 - All expenses are included except for diagnostic testing.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for documented service ML102 and is not indicated for submitted service ML104.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 10/27/2015 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$4,250.00	\$435.66	\$3,814.34	1	\$625.00	ML102 \$189.34 Due Provider Refer to Analysis

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