

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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10/8/2013

**Independent Bill Review Medical/Legal Final Determination Upheld**

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 3/12/2013 – 3/12/2013  
MAXIMUS IBR Case: CB13-0000273

Dear [REDACTED], M.D.,

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/19/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- 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
- Medical Legal Fee Schedule in effect July 1<sup>st</sup>, 2006

**Supporting Analysis:**

The dispute regards the amount paid for Medical-Legal services (ML103 Modifier 95) on date of service 3/12/2013. The Provider billed Medical-Legal code ML103 Modifier 95, was reimbursed \$625.00 and is requesting an additional reimbursement of \$312.50. The Claims Administrator based the reimbursement on ML102, for billed code ML103, indicating "Based on the documentation the following factors were met for determining the level of reimbursement: two hours of record review. However per the ML FS the following are not considered factors or were not met: causation and apportionment ."

The description of Medical-Legal code ML102 is "Basic comprehensive Medical-Legal Evaluation. Includes all comprehensive medical-legal evaluations other than those included under ML103 or ML104."

The description of Modifier 95 is "Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure."

The description of Medical-Legal code ML103 is 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, or if a bona fide issue of medical causation is discovered in the evaluation;
- (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 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) 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;
- (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.

(10) For dates of injury before December 31, 2012 where the evaluation 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.

The Medical-Legal report submitted by the Provider did not meet the required three complexity factors of ML103. The provider documented two hours of record review time, which qualifies as one complexity factor. The complexity factor of apportionment was not met. The report documented an evaluation or discussion of one injury to one body system or region (left wrist and thumb). The complexity factor of causation was not met. A bona fide issue of causation was not discovered in the evaluation. A written request for causation to be addressed was not submitted as part of the documentation. The report only met one of the ten complexity factors described in Medical-Legal code ML103.

Based on the documentation submitted, additional allowance for the disputed code is not warranted. The code assignment of Medical-Legal code ML102 by the Claims Administrator was appropriate. There is no additional reimbursement warranted per the Med-Legal code ML102 Modifier 95 based on the following calculation:

OMFS allowance for ML102 =RV 50 X 12.50 = \$625.00  
 Modifier 95 no additional reimbursement  
 OMFS allowance \$625.00 - \$625.00 (previously paid) = \$0.00

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ML102	95		1	\$312.50	\$625.00	\$625.00	\$0.00	OMFS

**Chief Coding Specialist Decision Rationale:**

This decision was based on OMFS Medical-Legal Fee schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$625.00 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[REDACTED], RHIT

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

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