

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

Independent Bill Review Medical/Legal Final Determination Upheld

4/10/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator Name: [REDACTED]
Date of Disputed Services: 4/23/2013 – 4/23/2013
MAXIMUS IBR Case: CB13-0000299

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/21/2013, 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 1st, 2006
- Other:

Supporting Analysis:

The dispute regards the payment amount for a Medical-Legal service (ML104 Modifier 93) performed on 4/23/2013. The Claims Administrator based its reimbursement of ML104 on the CPT codes 99245, 99358 and 99080 with the explanation "The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing."

ML104 - *Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances*. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:

(1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the 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.

(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;

(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. 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.

Modifier 93 - Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML 102 and ML 103.

The Provider submitted a report titled "QME Psychiatric Evaluation." The report documented a history of present illness, psychiatric evaluation, record review, summary and impression. The report documented 1.25 hours spent face-to-face with the injured worker, 2.75 hours were spent on review of records and 4.25 hours were spent in review and report preparation. Based on the documentation submitted, it does not appear the report meets the definition of a "Medical-Legal Expense. A "Medical-legal expense" is defined as " any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim." The Claims Administrator's authorization indicated the Provider was authorized to "evaluate and treat the injured worker." The Provider indicated in a letter addressed to MAXIMUS, the injured worker was referred to the Provider by a Treating Physician. The documentation did not indicate there was an issue of a contested claim, disputed medical fact or the Claims Administrator's authorization was for a Medical-Legal service. The Claims Administrator's authorization indicated an authorization for an evaluation and management service. The Claims Administrator reimbursed the Provider for a consultation (99245), additional allowance for the Modifier 93, 2.75 hours of prolonged services (99358 11 units) and a

