

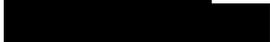
MAXIMUS FEDERAL SERVICES, INC.

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

7/30/2013

Independent Bill Review Medical/Legal Final Determination Reversed



Re: Claim Number: 
Claims Administrator name: 
Date of Disputed Services: 2/19/2013 – 2/19/2013
MAXIMUS IBR Case: CB13-0000063

Dear ,

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 5/31/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$625.00, for a total of \$960.00.**

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 amount paid for Medical-Legal services on date of service 2/19/13. The Provider billed Medical-Legal code ML104 Modifier 95, was reimbursed \$937.50 and is now requesting an additional payment of \$625.00. The Claims Administrator downcoded the billed code to ML103 and indicated " Procedure code ML104 was recommended as ML103, because the factor of addressing the issue of apportionment was not met."

The description of Medical-Legal code ML104 is " Comprehensive Medical-Legal evaluation involving extraordinary circumstances." The criteria for ML104 requires four or more of the ten complexity factors listed under ML103 to be met and documented by the Provider. 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." The criteria for ML103 requires three of the ten complexity factors to be met and documented by the Provider.

The description of the ten complexity factors listed in Medical-Legal code ML103 are as follows:

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 complexity factors (1-3), which shall count as two complexity factors.
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 bonafide issue of medical causation is discovered in the evaluation.
7. Addressing the issue of apportionment, when determining 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. 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. 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 met the required four complexity factors. The provider documented four or more hours of record review and face-to-face time, which qualifies as two complexity factors. The provider addressed the issue of causation in the report. Addressing the issue of causation qualifies as one factor. The fourth complexity factor was met by the documentation of apportionment. The provider specified at the beginning of the report which of the four complexity factors were met and documented in the Medical-Legal report.

The documentation submitted supports the reimbursement of Medical-Legal code ML104 Modifier 95. The code assignment of ML103 paid by the Claims Administrator was inappropriate. The additional reimbursement of \$625.00 for Medical-Legal code ML104 Modifier 95 is warranted based on the following calculation:

OMFS ML 104 15 minutes = 1 unit
 Modifier 95 no additional reimbursement
 Provider billed for 375 minutes (6 hours and 15 minutes)
 ML104 = 5 RV X 12.50 = \$62.50 X 25 (units) = \$1562.50

OMFS allowance \$1562.50 - \$937.50 (previously paid) = \$625.00

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
ML104	95		25	\$625.00	\$1562.50	\$937.50	\$625.00	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for Medical-Legal code ML104 Modifier 95 (\$1562.50-\$937.50=\$625.00) for a total of \$960.00.

The Claims Administrator is required to reimburse the provider \$960.00 within 45 days of date on this notice per section 4603.2 (2a). 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,

, RHIT

Copy to:



Copy to:

Division of Workers' Compensation Medical Unit
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