

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

8/20/2013

Independent Bill Review Medical/Legal Final Determination Reversed

[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/3/2013 – 4/3/2013
MAXIMUS IBR Case: CB13-0000099

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 6/21/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$1,484.37, for a total of \$1,819.37.**

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 4/3/2013. The Provider billed Medical-Legal code ML101 Modifier 94, was reimbursed \$1,171.88 and is requesting an additional reimbursement of \$1,484.54. The Claims Administrator based the reimbursement on ML103 for billed code ML101 indicating "The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the documentation submitted with the billing."

The description of Medical-Legal code ML101 is follow-up Medical-Legal Evaluation, limited to a follow-up Medical-Legal evaluation by a physician, which occurs within nine months of the date on which the prior Medical-Legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The description of Modifier 94 is Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25.

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 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 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.

The report submitted by the provider for date of service 4/2/2013 was a re-evaluation of the worker. The request for a re-examination by the Agreed Medical Evaluator on 4/3/2013 was documented in a letter to the worker dated 1/17/2013. The documentation indicated the prior evaluation of the worker by the Provider was on 8/20/12. The Medical-Legal evaluation on 4/3/2013 occurred within nine months of the prior Medical-Legal Evaluation. The Provider documented .5 hours of face-to-face time, four hours of past medical record and deposition review and six hours for AME report formulation. The Provider billed 34 units for Medical-Legal code ML101.

The documentation submitted supports reimbursement of Medical Legal code ML101 Modifier 94. The provider documented and billed for a total of 34 units for Medical-Legal code ML101 Modifier 94. The code assignment of ML103 by the Claims Administrator was inappropriate. The additional reimbursement of \$1,484.37 is warranted based on the following calculation:

OMFS allowance ML101 (1unit) = \$62.50
 Modifier 94 = 1.25
 ML101 = \$62.50 X 34 (units) = 2125.00 X 1.25 = 2,656.25

Recommended reimbursement = \$2656.25 - \$1,171.88 (prior payment) = \$1,484.37

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
ML101	94		34	\$1484.54	\$2656.25	\$1171.88	\$1484.37	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 101 Modifier 94 (\$2,656.25-\$1,171.88=\$1,484.37) for a total of \$1,819.37.

The Claims Administrator is required to reimburse the provider \$1,819.37 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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