

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

9/12/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000239	Date of Injury:	09/09/1997
Claim Number:	[REDACTED]	Application Received:	02/21/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/16/2013 – 11/16/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106 96		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/21/2014, 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
- Other: Title 8, California Code of Regulations, Chapter 4.5, Division of Workers' Compensation Subchapter 1, Article 5.6, §9795

Supporting Analysis:

The dispute regards reimbursement for Medical Legal services rendered by the Provider on 11/16/2013 for Med Legal Code ML 106.

The Claims Administrator initially denied the charges on 12/3/2013 with the following explanations:

1. The charge exceeds the official medial fee schedule allowance. The charge has been adjusted to the scheduled allowance.
2. Reimbursement is based on the applicable reimbursement fee schedule.
3. Claim is denied. No payment will be made.

On 1/22/2014, the Claims Administrator reviewed the initial claim a second time and reimbursed the Provider \$8,000.00 of the \$10,000.00 in overall charges for ML 106 with the following explanations:

1. The charge exceeds the official medial fee schedule allowance. The charge has been adjusted to the scheduled allowance.
2. Re-Reviewed at the providers request with additional information and documentation – additional payment suggested.

The Provider is seeking reimbursement for the remaining \$2000.00 for ML 106.

Title 8, California Code of Regulations, Chapter 4.5, Division of Workers' Compensation Subchapter 1, Article 5.6, §9795 defines ML 106 as follows:

“Evaluation which (A) does not involve an examination of the patient, (B) is based on the physician's review of records, test results or other medically relevant information which was not available to the physician at the time of the initial examination, or a request for factual correction pursuant to Labor Code section 4061(d), (C) 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 (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical legal evaluation.”

Upon review of the documentation presented with this IBR, it is noted that the Provider referenced a number of dates relevant to the patient's condition in order to present a clear and concise medical opinion relative to the patient's Workers' Compensation Claim. There is also a documented request to the Provider acknowledging an agreement to act as the Agreed Medical Evaluator for said case. It is therefore recognized that the chart documentation required for reporting code ML 106 were achieved.

The CMS1500 Health Insurance Claim Form, submitted by the provider for date of service 11/16/2013, did have the appropriate ML 106 reimbursement service code. However, it was noted that the necessary modifier associated with clarifying the need for ML 106, in this case an Agreed Medical Evaluator, was not submitted.

Title 8, California Code of Regulations, Chapter 4.5, Division of Workers' Compensation Subchapter 1, Article 5.6, §9795 recognizes an Agreed Medical Evaluator with the following modifier:

Modifier -94: Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator.

The modifier applied by the Provider for ML 106 was modifier -96. This modifier was deleted by the Division of Workers' Compensation in December of 2005. Based on the billing methodology, and the reporting guidelines, further reimbursement for this claim is not recommended.

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 Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ML 106		128	\$2,000.00	\$8,000.00	\$8,000.00	\$0.00	OMLFS

Chief Coding Specialist Decision Rationale:

This decision was based on aforementioned guidelines and comparison with OMFS. This was determined correctly by the Claims Administrator and the payment of \$8000.00 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,

██████████, RHIT
Chief Coding Reviewer

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