

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Medical/Legal Final Determination Reversed

6/11/2014

[REDACTED]

IBR Case Number:	CB14-0000013	Date of Injury:	12/18/2007
Claim Number:	[REDACTED]	Application Received:	1/6/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	7/25/2013 – 7/25/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104 Modifier 94 and 95		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/29/2014, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$820.31, for a total of \$1,155.31.**

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

Supporting Analysis:

The dispute regards the payment amount for Medical-Legal services (ML104 Modifier 94 & 95). The Claims Administrator reimbursed \$1,523.44 and applied a PPO discount of \$820.31 to the billed procedure code ML104 Modifier 94 and 95. The initial explanation of review (EOR) did not indicate a reason code for the reduction of \$820.31, other than the application of a PPO contract.

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 94 - 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. If modifier -93 is also applicable for an ML-102 or ML-103, then the value of the procedure is modified by multiplying the normal value by 1.35.

Modifier 95 - 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.

Per Medical-Legal Regulations, the cost of comprehensive, follow-up and supplemental medical-legal evaluations and medical-legal testimony shall be billed and reimbursed in accordance with the schedule set forth in CCR, Section 9795. According to CCR, Section 9795, fee for each evaluation is calculated by multiplying the relative value by \$12.50, and adding any amount applicable because of the modifiers permitted under subdivision. Unless the medical-legal provider and the payor have made a specific written agreement regarding medical-legal service payment at rates different than the Medical-Legal Fee Schedule (MLFS), a general MPN or PPO discount does not apply. A written agreement between the Claims Administrator and Provider was not submitted as part of the documentation. The Provider billed a total of 30 units for ML104 and appended Modifier 94 and 95. The report documented total of 7.5 hours of time spent on the following activities: 3 hours conducting the claimant's orthopedic physical examination; 1.5 hours of record review; and 3 hours of analysis, medical research and report preparation. The reduction of \$820.31 due to a PPO discount by the

Claims Administrator was not correct. Additional reimbursement is warranted for the billed Medical-Legal services billed under ML104 Modifier 94 and 95.

The additional reimbursement of \$820.31 is warranted per the Medical-Legal code 104 Modifier 94 and 95.

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
ML104	94 ,95	30	\$820.31	\$2,343.75	\$1,523.44	\$820.31	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 94 and 95 (\$820.31) for a total of \$1,155.31.

The Claims Administrator is required to reimburse the provider \$1,155.31 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).

[REDACTED]

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