

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 4, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001383	Date of Injury:	09/08/2008
Claim Number:	[Redacted]	Application Received:	09/22/2014
Claims Administrator:	[Redacted]	Assignment Date:	10/13/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-95-93		

Dear [Redacted]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above workers’ compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[Redacted]
Medical Director

cc: [Redacted]
[Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- Med-Legal OMFS

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE:** Provider disputing Med-Legal ML104-95-93 reimbursement for services performed on 05/21/2014.
- Claims Administrator reimbursement rational: “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.” And “The appended modifier code is not appropriate+ with the service billed.”
- Components of ML104 -95-93 services appear to be disputed by the Claims Administrator.
- Exhaustive search of documentation provided for this review, did not reveal a copy of the Authorization for Med-Legal services. As such, requested action items/issues the Provider was requested to address cannot be determined by IBR.
- Authorization for a Med Legal service not in dispute as Claims Administrator down-coded submitted ML104 service to ML103.
- **Evaluation Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:**
 - (1) **2** or more hours Face-to-Face time – **Criteria Not Met**, Provider States “1 hour.”
 - (2) 2 or more hours Record Review – **Criteria Met**, Provider states, “32 hours.”
 - (3) Two or more hours of medical research by the physician;
Med. Legal OMFS, “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” **Criteria Not Met** – Works Cited Page entitled “Addendum” included in Examination Report. Provider states, “0 hours.”

(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.”

Criteria Not Met – only complexity factor 2 of 1, 2 & 3 met.

(5) “Six or more hours spent on any combination **of three** complexity factors (1)-(3), which shall count as three complexity factors.” **Criteria Not Met**

(6) Causation – “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. **Criteria No Met** - Authorization for Med-Legal services not available for IBR, as such the “written request” for Causation cannot be verified.

(7) Apportionment – **Criteria Not Met**, Provider indicates, “Only when the claimant is determined permanent and stationary can apportionment then be determined.”

(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; **Criteria Not Met.**

(9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Not Met**

(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. Date of QME 05/21/2014. **Criteria Not Met,**

- **One (1)** Complexity Factor Abstracted From QME Report.
- **Criteria Not Met for ML104 service.**
- **Modifier-93 Definition:** 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.
- QME report noted the name of an interpreter. The report did not include a description or documentation of the additional time required for the examination as a direct result of the use of an interpreter. The documentation requirements for the reporting of Modifier -93 were not met.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement for ML104-95-93 is not warranted.

Date of Service: 05/21/2014							
Med-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104-95-93	\$13,250.00	\$937.50	\$12,312.50	N/A	1	\$937.50	Refer to Analysis
ML103	N/A	N/A	N/A	N/A	N/A	N/A	Service Not In Dispute, Refer to Analysis

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