

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 4, 2014

██████████
██████████
██████████

IBR Case Number:	CB14-0000311	Date of Injury:	01/19/2013
Claim Number:	██████████	Application Received:	03/05/2014
Claims Administrator:	██████████	Assignment Date:	07/13/2014
Provider Name:	██████████		
Employee Name:	██████████		
Disputed Codes:	ML104-95		

Dear ██████████

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$250.00 for the review cost and \$2,625.00 in additional reimbursement for a total of \$2,875.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2,875.00 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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,

██

Medical Director

cc: ██████████
██

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 Official Medical Fee Schedule

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 reimbursement for Med Legal services date on CMS 1500 form, 11/20/2013. Provider billed for ML104 - 95 services x 42 units.
- Claims Administrator reimbursed the Provider \$0.00 of \$2,625.00 billed charges for the following reason: "Duplicate Charge" stated on EOR 12/31/2013 and 02/18/2014.
- **Med Legal OMFS Modifier 95 Definition:** Panel QME
- **Letter of Authorization** from (Claims Administrator Legal Parties) dated 11/05/2013 confirming Med Legal Evaluation request for Injured Worker, and Appointment Date 11/19/2013. Only the first and last pages of the letter are present for IBR; exhaustive search for complete letter resulted in identical two pages present for this IBR.
- **Date of Actual Patient Exam:** 11/19/2014 as stated by Provider on the first line of the report as follows, "I examined (Injured Worker) on 11/19/2013, for evaluation of his shoulder..."
- **Submitted Service Date 11/20/2013** is the transcribed and signature date.
- **Date of Service is 11/19/2013.**
- **Authorization reflects 11/19/2013 Med Legal Service Request.**
- **QME Evaluation Documentation compared to ML104 OMFS "4 or more complexity factors" requirement:**
 - (1) 2 or more hours Face-to-Face time – **Criteria Met**, Provider States "2 hours."
 - (2) 2 or more hours Record Review – **Criteria Met**, Provider states, "3.5 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 Met** – Works Cited Page included in QME Report. Provider states, “5 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 Met

(5) “Six or more hours spent on any combination **of three** complexity factors (1)-(3), which shall count as three complexity factors.” **Criteria 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.” Authorization for Causation could not be found in IBR documentation – only 2 pages received of the 10 page authorization. **Criteria Not Met**

(7) Apportionment - **Criteria Met**

(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 11/20/2013. **Criteria Not Met,**

- **Four (4) Complexity Factors Abstracted From QME Report.**
- **Criteria Met for ML104-95**
- **Time Factors:**
 - Face to Face: 2 hours = 8 Units
 - Record Review: 3.5 Hours = 14 Units
 - Research: 5 Hours = 20 Units
 - Total Units = 42
 - Signed Attestation by Provider dated November 20, 2013, Page 18 of QME Report

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation, reimbursement is warranted and recommended for ML104-95 services.

Date of Service: 11/20/2013 for 11/19/2013							
[REDACTED]							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104-95	\$2,625.00	\$0.00	\$2,625.00	N/A	1	\$2,625.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
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