

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 2, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000505	Date of Injury:	11/11/2011
Claim Number:	[REDACTED]	Application Received:	03/28/2014
Claims Administrator:	[REDACTED]	Assignment Date:	06/20/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-93		

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: 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 \$335.00 for the review cost and \$1,812.50 in additional reimbursement for a total of \$2,147.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$2,147.50 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,

[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 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 questioning \$0.00 reimbursement for ML104-93 Med. Legal Services performed on 11/19/2013.
- Claims Administrator reimbursement Explanation codes and definitions as listed on the EOR are as follows:
 - G59 & X892: “The modifier code is not valid for this procedure.”
 - 30104: Definition not listed
 - Explanation code “30104” definition not listed on 1st EOR 01/22/2014 or 2nd EOR 03/14/2014.
- **Med. Legal OMFS Modifier -93 definition and instructions:** “-93 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. This modifier shall only be applicable to ML 102 and ML 103.”
- ML104 services billed.
- Modifier -93 not valid for ML104 services.
- EOR 01/22/14 and 03/14/2014 reflect Modifier -93 submitted.
- CMS 1500 form reflects Modifier -93 submitted by Provider.
- Second Bill Review Request Form does not indicate a modifier.
- Modifier -95: Qualified Medical Examiner indicated on IBR Request received 3/28/2014.

- Date of Service for Evaluation: December 3, 2013
- Date of Evaluation Signed by QME: December 19, 2013
- Provider is a QME = 95
- No indication Interpreter utilized during service – use of Modifier 93 not indicated for service.
- EOR's do not indicate Claims Administrator is contesting Medical Legal Services.
- EOR date corresponds with signature date of QME.
- IBR abstracted the following information from 10/20/13 report:
 - QME "Supplemental Report" dictated by Provider on October 20, 2013.
 - Supplemental Report referenced the following QME "report" services performed by Provider: July 16, 2012; July 29, 2013; and September 13, 2013.
 - Provider requests "**Re-Evaluation.**"
 - Letter from Legal Parties addressed to Provider requesting Provider to notify corresponding parties of need for "**re-evaluation.**"
 - Proof of notification signed 10/23/13 indicates Provider sent notification to all concerned parties of "**QME re-exam 11/19/13.**"
- QME Report dated 12/3/2013, for Date of Service 11/19/2013, Provider states "(Injured Worker) was **re-evaluated** in my office..."
- **OMFS Follow-up Medical-Legal Evaluation** definition and instructions: "Limited to a follow-up medical-legal evaluation by a physician this 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 physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour."
- Documentation provided indicates Injured Worker first evaluated by Provider on July 16, 2012.
- Documentation provided indicates Injured Worker evaluated on September 13, 2013.
- Documentation provided indicates Provider submitted a 'Supplemental **Report**' dated October 20, 2013.
- September 13th, 2013, last Med-Legal Evaluation performed to Tuesday, November 19, 2013, date of service for this claim, is **67 days**. This is equal to **2 months and 6 days** which is within "nine months" of the last Med-Legal Evaluation.
- Abstracted information reflects ML101 Follow-up Medical-Legal Evaluation service performed.
- Abstracted ML101 time as presented by Provider on Med-Legal report is as follows:
 - 260 Minutes Face-to-Face time.
 - 200 Minutes Record Review
 - 180 Minutes Report Prep
 - Total: 640 Minutes
 - Total Units = 43
 - Provider Seeking Reimbursement for 29 Units.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation provided, additional reimbursement is warranted for ML104-94 as ML101-95 Service.

Date of Service: 11/19/2013							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104-93	\$1,812.50	\$0.00	\$1,812.50	N/A	43	\$1,812.50	ML101-95 Service Recommended, reimbursable at billed rate.

Copy to:

[REDACTED]

Copy to:

[REDACTED]