

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 2, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000811	Date of Injury:	03/26/2013
Claim Number:	[Redacted]	Application Received:	06/02/2014
Claims Administrator:	[Redacted]	Assignment Date:	08/25/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-94, 72050, 73030, 73030 and 99499 (77 Units)		

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 \$250.00 for the review cost and \$781.25 in additional reimbursement for a total of \$1,812.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,812.50 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 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 ML104,72050, 73030, 73030 and 99499 (77 Units).**
- Claims Administrator ML104 reimbursement rational: “Service Non Compensable.”
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- DOS January 6, 2014 **X-ray CPT Codes: 72050, Neck/Spine; 73030, Shoulder (2 units, Rt, Lt); 99499 (77 Units) Unlisted Service.**
- **Authorization** dated January 3, 2014 from (Legal Parties) confirms Provider chosen as “Panel Qualified Medical Examiner.”
- Authorization requests PQME Provider to examine Injured Worker and provide written answers to the following (summarized) questions: 1) Detailed medical history 2) Diagnosis 3) If findings are consistent to original claimed injuries 4) Necessity of Future Medical Treatment 5) If Industrial or aggravated injury; cumulative trauma, and cause 6) If Industrial or aggravated injury; temporary, partial, duration status 7) Permanent and Stationary Rating 8) Return to work status 9) Future Medical Treatment; relieve or cure probability.

- Authorization, page 5, “This letter constitutes your authority to perform all tests which you believe are necessary. However, if hospitalization is necessary, the parties would require you to obtain consent.”
- **OMFS Med-Legal Modifier -94** Description: Agreed Medical Examiner
- Med-Legal ML104: “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.”
- **ML104 Complexity Factors 1 – 10 of 10:**
 - (1) Two or more hours of face-to-face time by the physician with the injured worker. **Not clearly defined in 77 page QME report, Criteria Not Met.**
 - (2) Two or more hours of record review by the physician. **“315 minutes” Criteria Met.**
 - (3) Two or more hours of medical research by the physician. **Criteria Not Met**
 - (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 one complexity factor clearly indicated in report.**
 - (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) Addressing the issue of medical causation, upon written request: **Criteria Met**
 - (7) Apportionment: **Criteria Not Met, “Apportionment will not be addressed at this time,” page 75 of PQME report.**
 - (8) Medical Monitoring of an employee following a toxic exposure to chemical mineral or biological substances. **Criteria Not Met**
 - (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Not Met.**
 - (10) Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met.**
- Documentation does not meet the criteria indicated for ML104-94 Med-Legal Service.
- **X-rays 72050, Neck/Spine; 73030, Shoulder (2 units, RT, LT);** Page 74, “Diagnostic Studies,” documentation does not clear. IBR not able to discern whether the Provider is referring to a report of findings relative to the x-ray’s in question or if the Provider actually performed, and then interpreted, the films.
- **99499 (77 Units) Unlisted Service:** CMS 1500 form does not list service. Unlisted Service information found on Invoice dated 2/6/2014 as follows: 99499 Transcription \$6.50 [77], Charge 500.50.
- **§9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.** (d). The fee for each medical-legal evaluation procedure **includes** reimbursement for the history and physical examination, review of records, preparation

