

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000235	Date of Injury:	11/17/2009
Claim Number:	[REDACTED]	Application Received:	02/21/2014
Claims Administrator:	[REDACTED]	Assignment Date:	11/12/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-94 and 96100		

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 \$7,349.46 in additional reimbursement for a total of \$7,684.46. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$7,684.46 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]
[REDACTED]

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
- Official Medical -Legal Fee Schedule
- DWC QME AME Fact Sheet

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 ML104-94 and 96100 Psychological Med Legal services provided to Injured Worker on 09/12/2013.
- Claims Administrator denied reimbursement with the following rationale: "Payment is denied as service not authorized."
- Total Billed Charges: \$7,349.46
- Provider Reimbursed: \$0.00
- **Article 5.6 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations §9793 (h)** "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, **for the purpose of proving or disproving a contested claim.** The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:
 - (1) The report is prepared by a physician, as defined in Section 3209.3 of the Labor Code.
 - (2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who

requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues

- **Letter of Authorization** from Defendant and Applicant Legal Parties dated (no date indicated), addressed to Provider, confirming the request for a Provider was “**selected** as the Qualified Medical Evaluator **from a panel provided by the Medical Unit...**”
- **Letter of Authorization provided the Provider with “authority to perform all tests believed necessary.”**
- **Division of Workers’ Compensation QME and AME Fact Sheet:**
“What’s the difference between a QME and an AME? If you have an attorney, your attorney and the claims administrator may agree on a doctor without using the state system for getting a QME. The doctor they agree on is called an AME. If they cannot agree, they must ask for a QME.”
- **Modifier -94 Criteria Not Met** - Provider is a QME “selected... from a panel provided by the medical unit.” **Modifier -95**
- **Date of Actual Patient Exam:** 09/12/2013 as reflected on examination report.
- **Submitted Service Date on CMS 1500 form:** 09/12/2013
- **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, “20.5 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 Not Met** – in accordance with §9793 (j): "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the *Guides for the Evaluation of Permanent Impairment* (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the *Physicians' Guide*), or other legal materials.”
Provider states “15 min.”
 - (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 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.” Request for Causation can be found on Authorization, Page 2, Issues 7, addressed on Page 106. **Criteria Met**
 - (7) Apportionment – **Criteria Met**, pages 107 - 110, of PQME Report.
 - (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 09/12/2013. **Criteria Not Met,**
- **Four (4)** Complexity Factors Abstracted From QME Report.
- **ML104** – Attestation pursuant to §9795, Reasonable Level of Fees for Medical-Legal Expenses and CLC §139.3, included in Examination Report, page 113 of PQME Report (**note** QME Report reviewed is an unsigned copy).
- **96100 Psychological testing, per hour.**
- Time Factors:
 - Face to Face: 2 hours = 8 Units
 - Record Review: 20 hours 30 min = 82 Units
 - Research: 15 min = 1Units
 - Report Prep: 4 hours 15 min = 17 Units
 - 27 Hours = 108 Units
 - Psychological Testing = 8 hours = 8 Units

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 (as -94) and 96100 services.

Date of Service: 09/12/2013							
Med. Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104-95(94)	\$7,349.46	\$0.00	\$7,349.46	N/A	108	\$6,750.00	\$6,750.00 Due Provider
96100	\$599.46	\$0.00	\$599.46	N/A	24	\$599.46	\$599.46 Due Provider

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