

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 27, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001622	Date of Injury:	04/22/2013
Claim Number:	[REDACTED]	Application Received:	10/27/2014
Claims Administrator:	[REDACTED]	Assignment Date:	12/10/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104, 95851,95832,72100 and 73030		

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 \$0.00 in additional reimbursement for a total of \$250.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$250.00 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,

[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
- AMA CTP 2014
- 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, 95851, 95832, 72100 and 73030 services performed on 07/26/2014.**
- Claims Administrator reimbursed \$0.00 of \$2,348.98 with the following rationale: “These are non-covered services because this is not deemed a Medical Necessity by the payer.”
- Authorization for services, dated May 8, 2014 signed by the Claimant and Defendant Legal Parties, addressed to the Panel Qualified Medical Examiner (Provider) reflects authorization for Med-Legal Services.
- The following requests are noted on the Authorization:
 - Medical Exam
 - Detailed History
 - Diagnostic tests (Provider) deems as “reasonable and necessary...”
 - Address 16 direct issues/questions
 - Causation and Apportionment (issue 10).
- **ML104 Med. Legal Definition:** “An evaluation which requires four or more of the complexity factors...”
- **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 “90 hours.”
 - (2) 2 or more hours Record Review – **Criteria Not Met**, Provider states, “There were no medical records for review at the time of her examination.”

- (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 Not 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 10. **Criteria 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 07/26/2014. **Criteria Not Met.**
- **Three (3) Complexity Factors Abstracted From QME Report.**
- Criteria not met for ML104, recommend reimbursement for **ML103.**
- Pages 8 – 13 of QME Report reflect the following authorized services were performed:
- **CPT 95851** Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine).
- **CPT 95832** Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side.
- **CPT 72100** X-ray exam l-s spine 2/3 views.
- **CPT 73030** Radiologic examination, shoulder; complete, minimum of 2 views.
- EOR 11/08/2014 reflects full payment of billed services to the Provider after IBR case creation date of 10/27/2014.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement is warranted for ML104, 95851, 95832, 72100 and 73030.

Date of Service: 07/26/2014							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$2,125.00	\$0.00	\$2,125.00	N/A	34	\$937.50	Reimburse as ML103 Provider Reimbursed Full Amount of Billed Services = \$0.00 Due Provider. Refer to Analysis
95851	\$63.99	\$0.00	\$63.99	N/A	3	\$63.99	Refer to Analysis
95832	\$29.69	\$0.00	\$29.69	N/A	1	\$29.69	Refer to Analysis
72100	\$61.02	\$0.00	\$90.00	N/A	1	\$61.02	Refer to Analysis
73030	\$105.28	\$0.00	\$105.28	N/A	2	\$105.28	Refer to Analysis

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