

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 28, 2016

[Redacted]

IBR Case Number:	CB16-0000007	Date of Injury:	03/22/2014
Claim Number:	[Redacted]	Application Received:	01/04/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	02/20/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-94-95		

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 \$195.00 for the review cost and \$4,906.25 in additional reimbursement for a total of \$5,101.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$5,101.25** 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,

Paul Manchester, M.D., M.P.H.
Medical Director

cc: [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 ML104-94-95 services submitted for date of service 02/20/2015.**
- The Claims Administrator down coded ML 104 to a ML 102 and reimbursed services \$781.25 with the following rationale: “the charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.” Claims Administrator also disputing the timeliness of second bill review.
- Provider submitted AME or QME Declaration of Service of Medical – Legal Report dated 7/18/2015 which falls within the timeframe of the second bill review for this claim.
- Communication dated 2/18/15, generated by legal party, identifies the Provider as the requested Panel QME for date of service 2/20/2015.
- **Evaluation Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:**
 - (1) 2 or more hours Face-to-Face time
 - (2) 2 or more hours Record Review
 - (3) Two or more hours of medical research by the physician;
 - (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: 1.0 hour for history and physical examination**

time with patient” and “19.75 hours of record review” (2.0 hours report preparation including editing)

- (5) “Six or more hours spent on any combination of **three** complexity factors (1)-(3), which shall count as three complexity factors.”
- (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.” **Criteria Met on page 19 of Provider’s report.**
- (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 – QME Request does not indicate psychiatric or psychological evaluation.**
- (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. **Criteria Not Met, Date of QME 02/20/2015.**
- **Three (3) Complexity Factors Abstracted From QME Report.**
- ML104 requires: (2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;
- Provider was requested by legal party to discuss patient’s prior injuries to the hip, shoulder and knee.
- Provider’s report documents patient complains of right shoulder, right elbow, right hand, lumbar spine, bilateral hips and right knee pain. These injuries also stated in Provider’s Review of Medical Records, Physical Examination and Discussion (Causation).
- Criteria met for ML104, recommend reimbursement for documented service **ML104.**
- Provider appended modifier -94: Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. Provider was not requested as the AME but the QME. Increased service value not warranted.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for ML104.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 02/20/2015							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$7,109.38	\$781.25	\$6,328.13	N/A	91	\$5,687.50	\$4,906.25 Due to Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
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