MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 17, 2020

REDACTED
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IBR Case Number	CB20-0001346
Claim Number	REDACTED
Assignment Date	11/02/2020
Claims Administrator	REDACTED
Date(s) of service	03/09/2020 – 03/09/2020
Provider Name	REDACTED
Employee Name	REDACTED
Disputed Codes	ML103-94, 93000, 93010, 94726, 93306, 93978, and 36410-59
Date of Injury	11/03/2014
Application Received	09/15/2020

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 $180.00 for the review cost and $1,143.57 in additional reimbursement for a total of $1,323.57. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,323.57** 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,

MAXIMUS Federal Services

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
- OMFS

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 is seeking remuneration for ML103-94, 93000, 93010, 94726, 93306, 93978, and 36410-59 submitted for date of service 03/09/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 10/15/2020. Response not yet received.
- CMS 1500, place of service 11
    - ML103-94
    - 93000
    - 93010
    - 94726
    - 93306
    - 93978
    - 36410-59
- EORs reflect zero reimbursement with the rationale: claim adjudicated as non-compensable.
- Appointment Confirmation Letter from the Claims Administrator dated 02/21/2020, indicated the purpose of the appointment was for an AME Re-Examination.
- CPT Code Descriptions
    - 93000: Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
    - 93010: Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only
    - 94726: Plethysmography for determination of lung volumes and, when performed, airway resistance
    - 93306: Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography
    - 93978: Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
    - 36410: Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
- Submitted AME report page 6 indicates: "A complete blood count, urinalysis and chemistry panel were performed at (Name Redacted) Clinical Laboratory." Submitted AME report page 13 indicates: "I personally…obtained the blood samples and interpreted the laboratory test results." Test results and interpretation were included within the report. **36410-59 Overturn.**
- Submitted AME Report page 6 indicated an electrocardiogram was performed with an interpretation and report substantiating CPT 93000. ECG results were attached and incorporated into the AME report. CPT 93010 is for the interpretation and report only, which is included in CPT 93000. **93000 Overturned and 93010 Upheld.**
- Submitted AME Report on page 7 indicates an echocardiogram was performed, results were attached and incorporated into the AME report. The echocardiogram report included 2D measurements, M-mode measurements and examinations of the left ventricle, Doppler of mitral, tricuspid, pulmonic and aortic valves, and abdominal aorta. **93306 Overturned.**
- Submitted AME report does not appear to support 93978. There is no mention of this test having been performed, no results or interpretations were found in the submitted documentation. Therefore, the service cannot be substantiated as being performed. **93978 Upheld.**

- Submitted AME report does not support 94726. There is no mention of this test having been performed, no results or interpretations were found in the submitted documentation. Therefore, the service cannot be substantiated as being performed. **94726 Upheld.**
- The Provider billed ML103-94 and specified the following times on page 2 of the Report
    - Face-to-Face Time: 1 hour
    - Review of records: 2 hours
    - Total hours spent on case: 3 hours
- The Provider indicated the following complexity factors as met on page 2 of the Report. "This was a complex evaluation and met the criteria for an ML103 designation for the following reasons: (1) I spent 2 hours reviewing the records. (2) At your request I addressed causation. (3) At your request I addressed apportionment. (4) I spent 1-hour interviewing and examining the patient."
- Med-Legal OMFS Code Description:
    - **ML103**: Complex Comprehensive Medical-Legal Evaluation.
    - An evaluation which requires three or more of the Complexity Factors; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. 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.
    - **Complexity Factor 2 – Criteria Met (One (1) Complexity Factors)**
        - Two or more hours of record review by the physician;
            1. Record Review 2 hours
            2. List of records reviewed and summarized on pages 7-9 of the AME Report
    - **Complexity Factor 6 – Criteria Not Met**
        - Addressing the issue of medical causation, upon written request of the party or parties requesting the report
        - Medical directives were requested on Assignment 11/02/2020; response not yet received. On page 2 of the AME Report Provider indicated "per your request I addressed causation."
        - Causation was addressed on page 10 of the AME report, however no request to address causation was submitted for review.
    - **Complexity Factor 7- Criteria Not Met**
        - Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of Guides to the Evaluation of Permanent Impairment (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
        - Apportionment was addressed on page 12 of the AME report
        - "I conclude that approximately 100% of (Name Redacted) permanent internal medical disability from hypertension and palpitations was caused by the direct result of injury arising out of and occurring in the course of employment at (Name Redacted) and approximately 0% was directly caused by factors other than employment."
        - Apportionment only included evaluation of two injuries to the same body area/system.

- One (1) complexity factor was abstracted from the report. Submitted AME report does not meet the definition of a ML103. The report does meet the definition of an ML102 Basic Comprehensive Medical-Legal Evaluation. **ML103-94 Overturned as ML102-94.**
- Use of the modifier -94 is supported. Letter from the Claims Administrator to the Injured Worker dated 02/21/2020 indicates an appointment was made for an AME Re-Examination. Provider's AME report indicates on page 1: "(Name Redacted) returned to my office for an Agreed Medical Examination in the field of internal medicine on 03/09/2020."
- Zero reimbursement was received. Reimbursement is due for ML103-94 as ML102-94, 93000, 93306, and 36410-59. EORs do not reflect a PPO is in effect. Reimbursement will be based on 100% OMFS.
- OMFS 2020 Geographic Practice Cost Index by locality corresponding to the county where service was provided:
    - Provider Zip: REDACTED
    - Locality: REDACTED, CA
    - 93000 Work RVU + GPCI: 0.17799; Non-Facility PE RVU + GPCI: 0.34104; MP RVU + GPCI: 0.0145
    - 93306 Work RVU + GPCI: 1.5705; Non-Facility PE RVU + GPCI: 5.04504; MP RVU + GPCI: 0.05075
    - 36410 Work RVU + GPCI: 0.18846; Non-Facility PE RVU + GPCI: 0.34104; MP RVU + GPCI: 0.0145
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for ML103-94 as ML102-94, 93000, 93306 and 36410-59 and reimbursement is not indicated for 93010, 94726, 93306 or 93978.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML103-94, 93000, 93010, 94726, 93306, 93978, and 36410-59

Date of Service: 03/09/2020

Med-Legal

Service Code	ML103-94
Provider Billed	$1,171.88
Plan Allowed	$0.00
Dispute Amount	$1,171.88
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$781.25
Notes	**Overturn as ML102-94** $625.00 (OMFS) * 1.25 (use of modifier -94) = **$781.25** **Due Provider** Refer to Analysis

Service Code	93000
Provider Billed	$24.96
Plan Allowed	$0.00
Dispute Amount	$24.96
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$24.96
Notes	**Overturn** 0.53353 (RVU & GPCI Total) * 46.7900 (CF) = **$24.96** **Due Provider** Refer to Analysis

Service Code	93010
Provider Billed	$11.96
Plan Allowed	$0.00
Dispute Amount	$0.00
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$0.00
Notes	**Uphold** Refer to Analysis

Service Code	94726
Provider Billed	$81.09
Plan Allowed	$0.00
Dispute Amount	$29.20
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$0.00
Notes	**Uphold** Refer to Analysis

Service Code	93306
Provider Billed	$311.91
Plan Allowed	$0.00
Dispute Amount	$311.91
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$311.91
Notes	**Overturn** 6.66629 (RVU & GPCI Total) * 46.7900 (CF) = **$311.91** **Due Provider** Refer to Analysis

Service Code	93978
Provider Billed	$285.58
Plan Allowed	$0.00
Dispute Amount	$285.58
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$0.00
Notes	**Uphold** Refer to Analysis

Service Code	36410-59
Provider Billed	$25.45
Plan Allowed	$0.00
Dispute Amount	$25.45
Assist Surgeon	N/A
Units	1
Workers' Comp Allowed Amt.	$25.45
Notes	**Overturn** 0.544 (RVU & GPCI Total) * 46.7900 (CF) = **$25.45** **Due Provider** Refer to Analysis

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