

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 24, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000128	Date of Injury:	11/15/2012
Claim Number:	[REDACTED]	Application Received:	01/29/2016
Assignment Date:	02/17/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/15/2015 – 10/15/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-94		

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 \$781.25 in additional reimbursement for a total of \$976.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$976.25** 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]

[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 seeking remuneration for ML104-94 Agreed Medical Examiner services performed on 10/15/2015.**
- The Claims Administrator denied services requesting re-submission with “ICD.10” coding.
- Med-Legal Services do not require ICD.10 coding.
- AME request **revealed ML104 extraordinary** circumstances with causation and specific apportionment requested.
- Modifier – 94 increases fee by 25%.
- AME report reviewed; Causation and Apportionment yet to be determined.
- **AME Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:**
 - (1) 2 or more hours Face-to-Face time – **Criteria Met**, Page 15 of AME Report, the Provider indicates **“2 hours.”**
 - (2) 2 or more hours Record Review – **Criteria Met**, Page 15 of AME Report, the Provider indicates, **“6 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**
 - (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.” **Criteria Not Met**
 - **Directive from Claims Administrator/Legal Parties’ request of causation not fulfilled.** Page 14 of AME report indicates “I will issue a definitive opinion regarding causation ion once I have reviewed the medical records.”
 - (7) Apportionment – **Criteria Not Met**
 - **AME Authorization** indicates request of “whole person impairment rating” if applicant has yet to reach maximal medical improvement.
Apportionment percentage not indicated. Page 14 of AME report, the Provider indicates “apportionment percentage values along with a detailed rational will be provided when maximum medical improvement has been established and permanent impairment rating is performed.”
 - (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 – Provider’s Specialty is Orthopedic Surgery and Sports Medicine.**
- (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 AME 10/15/2015.**
- **Two (2) Complexity Factors Abstracted From AME Report.**
- **Criteria not met for ML104, recommend reimbursement for documented service ML102.**
- **ML102 - A basic medical evaluation which does not meet the criteria of any other medical-legal evaluation.**
 - Paid at a flat rate.
 - All expenses are included except for diagnostic testing.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for ML102 and is not indicated for ML104.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 10/15/2015						
Med-Legal						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
ML104	\$2,500.00	\$0.00	\$2,500.00	36	\$781.25	ML102 - 94 Refer to Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]