INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 24, 2014

Dear [Provider Name],

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.

IBR case assigned: 04/02/2014

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 $7675.25 in additional reimbursement for a total of $8010.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $8010.25 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 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

[Chief Coding Reviewer]

cc: [Claims Administrator]

[Table]

<table>
<thead>
<tr>
<th>IBR Case Number:</th>
<th>CB13-0000495</th>
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<tr>
<td>Date of Injury:</td>
<td>04/06/2009</td>
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<tr>
<td>Claim Number:</td>
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<td>Application Received:</td>
<td>09/19/2013</td>
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<td>Claims Administrator:</td>
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<td>Provider Name:</td>
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<tr>
<td>Employee Name:</td>
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<tr>
<td>Disputed Codes:</td>
<td>ML104 94 &amp; 96100</td>
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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 Fee Schedule
- Negotiated contracted rates: OMLFS
- National Correct Coding Initiatives
- Other: Official Medical Legal 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 dissatisfied with reimbursement of code ML104 94 & 96100.
- The dispute regards Medical Legal Service charges for dates of service 01/03/2013. The Provider is a Qualified Medical Examiner who agreed to conduct a medical legal evaluation on an injured worker for the Claims Administrator. Submitted charges form the Provider included a ML104 -94 evaluations and CPT Code 96100; billed to the Claims Administrator for a total of $8343.75. The Claims Administrator issued a partial reimbursement of $687.50 for the following reasons:
  - ML104 – 94: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance; AME Performed Evaluation; Billing Greater Than Medical Legal Allowance
  - 96100: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.
• Upon review of the Medical Legal Report provided, the complexity of the report was analyzed and compared to Complexity Factors 1 – 10. Complexity Factors 4, 6, 7 and 9 were met. ML104 criteria met: four or more complexity factors
• Complexity factors addressed below:
  • Complexity factor #4: Criteria Met: 1 & 2 = **16 hours in combination of two complexity factors 1-3**.
  • Complexity factor 6: Addressing this issue of Causation, Criteria met
    o Beginning on page 5 of the Medical Legal Report
  • Complexity Factor #7: Addressing the issue of Apportionment, Criteria Met
    o Refer to Pages 38 – 39 of the Medical Legal Report
  • Complexity factor #9: A psychiatric or psychological evaluation, Criteria Met
    o Refer to Pages 29 – 38 of the Medical Legal Report
    o Separate CPT Code billed in addition to Criteria 9.

• Time spent: Preparation of written report: 9.50 (38 units); face to face time 1.0 hours (4 units); and reviewing medical records 15 hours (60 units) = 102 units

• CPT Code 96100. The Provider stated “3 hrs” of time were utilized for this service on 1/3/13. The Claims Administrator reimbursed the Provider $375.00. The amount billed by the Provider is $375.00. Since the amount reimbursed amount is over the OMFS ($99.91 per unit hour), additional reimbursement is not warranted.
• The additional reimbursement of $7,656.25 for Official Medical-Legal Fee Schedule code ML 104 94 is warranted based on the following calculation:
The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code ML104 94 is warranted in the amount listed below.

<table>
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<th>Date of Service: 1/3/2013</th>
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<tbody>
<tr>
<td><strong>Service Code</strong></td>
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<tr>
<td>-------------------</td>
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<tr>
<td>ML104 94</td>
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