INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 20, 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.

**Final Determination: UPHOLD.** MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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,

[Medical Director]

cc:
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:** ML106-92 Services denied by the Claims Administrator for the following reason: “The Conditions necessary for Medical-Legal reimbursement per CCR 9793 have not been met.”
- **ML106:** Supplemental medical-legal evaluations.
- **Modifier -92:** Primary Treating Physician
- §9793 (m) “Supplemental medical-legal evaluation” means an evaluation which (A) does not involve an examination of the patient, (B) is based on the physician's review of records, test results or other medically relevant information which was not available to the physician at the time of the initial examination, or a request for factual correction pursuant to Labor Code section 4061(d)
- Subsequent Comprehensive Medical-Legal evaluation not available during the IBR Process; unable to verify billed ML106 service is:
  1) “supplementary” information to a subsequent Med-Legal Evaluation
  2) A correction to a previous Permanent and Stationary report.
- §9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony. Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.
The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML106-92**

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Provider Billed</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Assist Surgeon</th>
<th>Units</th>
<th>Workers’ Comp Allowed Amt.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ML106-92</td>
<td>$1,125.00</td>
<td>$147.09</td>
<td>$977.91</td>
<td>N/A</td>
<td>1</td>
<td>$147.09</td>
<td>Refer to Analysis</td>
</tr>
</tbody>
</table>

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