INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 24, 2014

Dear [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.

IBR Case Assigned: 04/23/2014

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,

[Name]

Chief Coding Reviewer

cc: [Names]
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
- Negotiated contracted rates:
- National Correct Coding Initiatives

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 ML101-95. The Claims Administrator Reimbursed $625.00, Provider submitted $1,250.00 claim.
- The Claims Administrator down-coded the billed ML101 to ML103 with the following explanation: “Initial ML was 8/31/2012. F/u is more than 9 mos. This should be billed as ML102. Initial review is correct based on history of ML Evaluation.”
- The Provider, an Orthopedic Surgeon, was requested by Legal Parties in the matter of (Injured Worker) v. (Employer/Claims Administrator) to perform a medical evaluation and render a medical opinion on the Injured Worker. The request is dated October 2, 2013.
- On January 14, 2014 the injured Worker was evaluated by The Provider as requested.
- The provided documentation entitled “Qualified Medical Evaluation” was reviewed and compared to the guidelines as dictated in the Med-Legal OMFS. The OMFS definition for ML101 states the following qualifying factor “Follow-up Medical-Legal Evaluation. Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed.”
- Limited documentation provided does not contain the initial QME report as such, the initial date of the visit cannot be verified for ML101 criteria. However, a letter from (Claims Administrator), dated April 14, 2014, clarifies the date of the initial exam as “08/31/12.”
• According to the documentation provided by the Provider, the Injured Worker was re-evaluated on November 8, 2013. A letter from the Claims Administrator to Maximus, dated April 15, 2014, has the Initial ML Evaluation as “8/31/12.” The Claims Administrator down coded ML101 to ML02 due to the fact that the Initial ML Evaluation was 8/31/12; the November 8, 2013 date of services did not occur “within 9 months of the Initial ML Evaluation.”

• Given the dates provided, IBR has determined that the Initial ML Evaluation is 8/31/2012.

• A qualifying factor for Med-Legal OMFS ML101 stipulates that a visit must occur “within nine months of initial ML Evaluation.”

• August 8, 2012, the Initial ML Evaluation, to November 8, 2013, the date of service in question, equates to 1 year, 7 months, and 24 days.

• Documentation provided supports the use of ML102, defined by Med-Legal OMFS: “Basic Comprehensive Medical-Legal Evaluation. Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.”

• IBR findings concur with Claims Administrator’s code assignment of ML102.

• Based on the aforementioned guidelines when compared to the documentation provided, specifically the factor of time in terms of months, the Provider has not met the Criteria for ML101.

**Determination of Issue in Dispute:** Reimbursement of code ML101-94, based on the aforementioned guidelines when compared to the documentation provided determines additional reimbursement is not warranted.

The table below describes the pertinent claim line information.

<table>
<thead>
<tr>
<th>Date of Service: 11/8/2013</th>
<th>Medical Legal Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Code</td>
<td>Provider Billed</td>
</tr>
<tr>
<td>ML101-94 (ML102)</td>
<td>$1,250.00</td>
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</tbody>
</table>