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: 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 $250.00 for the review cost and $6,898.91 in additional reimbursement for a total of $7,148.81. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $7,148.81 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,

Medical Director

cc: [Name]
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: Provider disputing reimbursement for ML104, 73110, 72110, 73562, 73030 and 72040 services performed on 03/27/2014.
- Claims Administrator ML104 reimbursement rational: “FCE Not Requested,” and “Not Authorized.”
- FCE “Functional Capacity”
- ML104 Med. Legal Definition: “An evaluation which requires four or more of the complexity factors…”
- Time factor relative to ML104 is in dispute.
- DOS 03/27/2013 X-ray CPT Codes: 73110, Wrist; 72210, L-2 Spine; 73562, Knee; 73030 Shoulder; and 72040, Neck/Spine.
- Notation on QME, Provider states, “I performed plain film x-rays of the cervical spine, BL shoulders and BL wrists,” followed by interpretation of each.
• **Authorization** dated March 3, 2014 from (Claims Administrator) confirms Provider chosen as “Qualified Medical Examiner.”

• Authorization requests Provider to examine Injured Worker in regards to “a dispute with the medical findings of the medical determination, regarding the following: a) Permanent and stationary status. b) The extent and scope of medical treatment. c) The employee’s preclusion or likely preclusion from engaging in his usual occupation. d) The level of permanent disability. e) The existence of new and further disability.

• Authorization for Physician to address the following issues: Injury, Diagnosis, Agree/Disagree Treating Physician’s Findings, Temporary Disability, Permanent and Stationary/Maximum Medical Improvement, Permanent Impairment, **Causation**, Apportionment, Medical Treatment, and Permanent Disability pursuant to the 2004 Permanent Disability Rating Schedule

• **FCE, and X-rays: 73110, 72110, 73562, 73030 & 72040** fall under Medical-Legal Expenses as indicated in §9794 Reimbursement of Medical-Legal Expenses as these services were performed, not for treatment, but as part of the Medical-Legal evaluation. Rational for the services can be found on the following pages:
  
  i. FCE, page 19
  
  ii. 73110, page 18
  
  iii. 72110, page 16
  
  iv. 73562, page 19
  
  v. 73030, page 18
  
  vi. 72040, page 16

• **FCE performed during ML104 evaluation time factor is as follows:**
  
  i. Time factor for FCE reported: 3 hours.
  
  ii. Time factor for ML104 reported:
    
    1. Face to Face: 2 hours 30 min + FCE (exam) = 5hours 30min
    2. Record Review: 1 hour 15 min.
    3. Research: 0 - Criteria Not Met (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.)
    4. Provider reports 31 hours 30 min of which 30 hours (120 units) are reportable.
    5. Signed Attestation by Provider dated 04/23/2014, page 32
The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for ML104, 73110, 72110, 73562, 73030 and 72040

<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>ML104-</td>
<td>$7,875.00</td>
<td>$1,250.00</td>
<td>$7,415.00</td>
<td>N/A</td>
<td>126</td>
<td>$7,750.00</td>
<td>124 Units Reportable. Provider Reimbursement - $7,750.00 = $6,500 Due Provider. Refer to Analysis.</td>
</tr>
<tr>
<td>73110</td>
<td>$180.00</td>
<td>$0.00</td>
<td>$180.00</td>
<td>N/A</td>
<td>5</td>
<td>$64.95</td>
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<tr>
<td>72110</td>
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<td>$0.00</td>
<td>$83.86</td>
<td>N/A</td>
<td>8</td>
<td>$180.00</td>
<td>Refer to Analysis</td>
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<tr>
<td>73562</td>
<td>$90.00</td>
<td>$0.00</td>
<td>$90.00</td>
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<td>$90.00</td>
<td>Refer to Analysis</td>
</tr>
<tr>
<td>73030</td>
<td>$160.00</td>
<td>$0.00</td>
<td>$160.00</td>
<td>N/A</td>
<td>6</td>
<td>$160.00</td>
<td>Refer to Analysis</td>
</tr>
<tr>
<td>72040</td>
<td>$180.00</td>
<td>$0.00</td>
<td>$180.00</td>
<td>N/A</td>
<td>6</td>
<td>$180.00</td>
<td>Refer to Analysis</td>
</tr>
</tbody>
</table>

Copy to: