INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 30, 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: 07/30/2014

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 $250.00 for the review cost and $2,500.18 in additional reimbursement for a total of $2,750.18. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $2,750.18 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,

cc: [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
- Medical 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 ML101-92. The Claims Administrator changed the submitted code to the following codes: 99080, 99215, 99358, 99354 and 99355, and reimbursed the Provider $499.82 out of the $3,000.00 service charge.
- The Provider is seeking additional reimbursement of $2,500.18 from the Claims Administrator.
- The CMS 1500 form copy provided indicates the provider billed ML101-92 on 5/08/2014.
- The Claims Administrator changed service code ML101-92 to codes 99080 (Special Reports), 99215 (Office/Outpatient E&M), 99358 (Prolonged Services without Pt. contact), 99354 (Prolonged Services – 1st hour) and 99355 (Prolonged Services – Each Additional 30).
- The Claims Administrator did not provide a reason for changing the ML101 – 92 to 99080, 99215, 99358, 99354 and 99355.
- 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.”
- OMFS Modifier -92: “Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.”
- The Provider, an Orthopedic Surgeon, was requested by Legal Parties in the matter of (Injured Worker) v. (Employer/Claims Administrator) to perform a follow-up medical evaluation and render a medical opinion on the Injured Worker.
- The formal request to the Provider from the Legal Party is dated April 14, 2014.
• The specific request from the above mentioned Legal Party stipulates, “… please provide your comprehensive medical legal report on each of the disputed issues.”
• EOR does not specify validity of ML101-92; code changed as mentioned earlier.
• On May 2, 2014 the Injured Worker was physically evaluated by The Provider for “two hours.”
• Per the Legal Party’s request, the Provider addressed the following:
  ♦ Nature and Extent of Permanent Disability – **Addressed on Page 8**
  ♦ Whole Person Impairment (WPI) – **Addressed on page 8**
  ♦ Apportionment, including if relevant, a Benson analysis – **Addressed on pages 13 & 14**
  ♦ AOE/COE – **Addressed on pages 10 through 14**.
  ♦ TTD Status – **Addressed on pages 14 through 18**.
  ♦ TPD Status – N/A (refer to pages 14 thorough 18 under TTD)
  ♦ Provider states, page 1 of the QME report, “Twelve hours were required to review all relevant records, re-examine the patient, and prepare this report.”
    - ML 101 - RV 5 Per 15 Min. $62.50/15 min or $250/hr
    - 12 hours = 48 units

**DETERMINATION OF ISSUE IN DISPUTE:** Based on the aforementioned guidelines when compared to the documentation provided determines additional reimbursement is warranted and recommended for code ML101-92 @ 48 units (12 hrs).

The table below describes the pertinent claim line information.

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