

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 22, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001417	Date of Injury:	12/14/2010
Claim Number:	[REDACTED]	Application Received:	08/21/2015
Assignment Date:	09/11/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/02/2015 – 04/02/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106-95		

Dear [REDACTED]

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 \$195.00 for the review cost and \$250.00 in additional reimbursement for a total of \$445.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$445.00** 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,

Paul Manchester, M.D., M.P.H.
Medical Director

Cc: [REDACTED]
[REDACTED]

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

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 seeking remuneration for ML106-95 services performed on 04/02/2015.**
- The Claims Administrator denied services based on need for “authorization.”
- Communication from the Claims Administrator’s Legal Parties, dated 03/06/2015, request the following from the Provider: “Defendant requests that you review your prior reports, as well as the applicant’s deposition testimony, and provide the parties with your opinion as to whether there was more than one period of continuous trauma.”
- **8 C.C.R. §§ 9793, 9795** Medical-Legal Fee Schedule Proposed Regulations (2) The report is obtained at the request of a party or parties, the administrative director, or the appeals board for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.
- **§9793(1)** "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, (C) results in the preparation of a narrative medical report prepared and attested to in accordance with Section 4628 of the Labor Code, any applicable procedures promulgated under Section 139.2 of the Labor Code, and the requirements of Section 10606 and (D) is performed by a qualified medical evaluator, agreed medical evaluator, or primary treating physician following the evaluator's completion of a comprehensive medical-legal evaluation.
- **ML106:** Supplemental medical-legal evaluations: Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.
- The aforementioned 03/06/2015 was requested by Legal Representation of the Claims Administrator for purposes of “proving or disproving” a claim.
 - It is noted the Claims Administrator’s Address presented on the request is not the address indicated on the CMS 1500 or the EOR. However, the Claims Administrator’s name and contact person is identical to that of the request.
- Supplemental Report reflects “1 hour”
- ML106-95 = ML 106 RV 5 Per 15 Min., \$62.50/15 min or \$250/hr.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for ML106-95.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106-95

Date of Service: 04/02/2015 Med-Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML106-25	\$250.00	\$0.00	\$250.00	4	\$250.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
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