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

# INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 2, 2015

[redacted]

| | | | |
|---|---|---|---|
| IBR Case Number: | CB15-0000657 | Date of Injury: | 01/15/2011 |
| Claim Number: | [redacted] | Application Received: | 04/28/2015 |
| Claims Administrator: | [redacted] | | |
| Date Assigned: | 5/26/2015 | | |
| 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 $687.50 in additional reimbursement for a total of $882.50. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of $882.50 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, MD, MPH
Medical Director

cc: [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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Medical Legal 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 is dissatisfied with reimbursement of ML 106 and denial of 99070
- Claims Administrator denied code 99070 indicating on the Explanation of Review "No separate payment was made because the value of the service is included within the value of another service performed on the same day"
- ML 106 - Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. 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.
- Reimbursement of 99070 is not warranted as time spent on Provider's report is included in the ML 106
- Provider was requested by the attorney to review new records and supply a report on an injured worker he previously evaluated.
- Provider's report submitted documents 2 hours of reviewing the records and 1 hour for preparing the report.

- Based on information reviewed, additional reimbursement of ML 106 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 106

| **Date of Service**: | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| **Service Code** | **Provider Billed** | **Plan Allowed** | **Dispute Amount** | **Units** | **Multiple Surgery** | **Workers' Comp Allowed Amt.** | **Notes** |
| ML 106 | $750.00 | $62.50 | $687.50 | 12 | N/A | $750.00 | **DISPUTED SERVICE**: Allow reimbursement $687.50 |

Copy to:

[redacted]

Copy to:

[redacted]