

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

May 31, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000755	Date of Injury:	04/01/1980-08/01/1985
Claim Number:	[REDACTED]	Application Received:	05/06/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/16/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106 (CA changed to 99199)		

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: 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.**

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,

Maximus

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
- Official Medical Fee Schedule
- Negotiated contracted rates: N/A
- 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 seeking remuneration of ML 106 for date of service 03/16/2016.
- Communication from the Claims Administrator dated November 9, 2015 requesting Provider as a Panel Qualified Medical Examiner for appointment date of service December 10, 2015 with a list of directives to submit in the report was submitted for this review.
- The submitted request does not mention any other medical records that would be sent later for his review and response.
- § 9795 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.**
- Provider's "Supplemental Report" dated March 16, 2016 documents in the first paragraph "The following medical reports were submitted for my review."

- A request/authorization from the Claims Administrator or legal party for additional record review with report was not identified.
- § 9793: (g)"Medical-legal expense" (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.
- ML 106 service does not appear to have been requested.
- Based on documentation submitted and guidelines, reimbursement for ML 106 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 106**

<b>Date of Service:</b> 03/16/2016					
<b>Medical Legal Services</b>					
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 106	\$125.00	\$0.00	\$125.00	\$0.00	<b>Refer to Analysis</b>

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