

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 18, 2014

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

| | | | |
|------------------------------|--------------|------------------------------|------------|
| IBR Case Number: | CB14-0001287 | Date of Injury: | 05/31/2007 |
| Claim Number: | [REDACTED] | Application Received: | 09/04/2014 |
| Claims Administrator: | [REDACTED] | Assignment Date: | 10/07/2014 |
| Provider Name: | [REDACTED] | | |
| Employee Name: | [REDACTED] | | |
| Disputed Codes: | ML106 | | |

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 \$250.00 for the review cost and \$5,250.00 in additional reimbursement for a total of \$5,500.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$5,500.00 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,

[REDACTED]
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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- Med-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 seeking remuneration for ML106-97 services performed on 07/11/2014.
- Claims Administrator reimbursed the Provider \$0.00 stating: “We cannot review service without necessary documentation, please submit Med Legal Report Necessary.”
- Med Legal Service Not in Dispute.
- Validation of ML106 service appears to be in dispute.
- Authorization for initial Med-Legal services from (Legal Parties) dated 4/13/2014 addressed to the Provider acknowledging AME status and evaluation of injured worker.
- **ML106 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 states in QME report, “thirty pounds of records (16 inches) that was to have been sent to me prior to my May 9, 2014 evaluation of the applicant.”
- Actual time spent, not provided in report.

- 2nd EOR 7/11/2014 Provider states “21 hours of time spent reviewing and assessing the records that were submitted, comments on these, as well as integrating the entire report.”
- 21 hours = 84 Units
- Modifier 97 – Not a Valid Modifier for Med-Legal Services

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106-97

| Date of Service: 07/11/2014 | | | | | | | |
|------------------------------------|------------------------|---------------------|-----------------------|-----------------------|--------------|-----------------------------------|-----------------------------|
| Med Legal Services | | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon | Units | Workers' Comp Allowed Amt. | Notes |
| ML106-97 | \$6,562.50 | \$0.00 | \$6,562.50 | N/A | 84 | \$5,250.00 | \\$5,250.00 Due Provider |

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