

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 22, 2014

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001303	<b>Date of Injury:</b>	08/22/2011
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	09/08/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	10/08/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	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 \$250.00 for the review cost and \$1750.00 in additional reimbursement for a total of \$2000.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2000.00 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:
- 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 is dissatisfied with denial of ML 106-95.
- Claims Administrator denied ML 106 indicating on the Explanation of Review “This service requires prior authorization and none was identified.”
- (k) "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.
- Documentation submitted included a request by the attorney for the Claims Administrator for Provider to address apportionment on the injured workers two injuries along with other requests. A Supplemental Report was submitted by Provider documenting apportionment along with the fulfillment of the requests by the attorney for the Claims Administrator.
- Based on documentation reviewed, Claims Administrator was incorrect to deny ML 106-95. Therefore, reimbursement of ML 106-95 is warranted.

- IBR does not initiate penalties and interest. That is the responsibility of the Provider.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 106-95 is recommended.

<b>Date of Service:</b> 3/15/2014							
<b>Medical Legal Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 106-95	\$1750.00	\$0.00	\$1925.00	28	N/A	\$1750.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1750.00

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