

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 9, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000855	Date of Injury:	05/03/2010
Claim Number:	[Redacted]	Application Received:	06/13/2014
Claims Administrator:	[Redacted]	Assignment Date:	07/15/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML101-95		

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: 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,

[Redacted Signature]

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
- Other: Title 8 Code Of Regulations, Section 9793

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 101 being reduced to ML 103 by Claims Administrator.
- ML101 - Follow-up Medical-Legal Evaluation. Limited to a follow-up medical-legal evaluation by a physician. Which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. 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.
- Pursuant Title 8 California Code of Regulations, Section 9793 (f) "Follow-up medical-legal evaluation" means an evaluation which includes an examination of an employee which (A) 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, (B) is performed by a qualified medical evaluator, agreed medical evaluator, or

primary treating physician within nine months following the evaluator's examination of the employee in a comprehensive medical-legal evaluation and (C) involves an evaluation of the same injury or injuries evaluated in the comprehensive Medical-Legal evaluation.

- Follow-up Medical-Legal Evaluation is performed within nine months following the evaluator's examination of the worker in a comprehensive Medical-Legal evaluation. The documentation submitted by the Provider and Claims Administrator indicated the prior Medical-Legal evaluation took place on date of service 09/11/2013 and per the Provider and Claims Administrator was a "Follow-up Re-Evaluation." The Claims Administrator's documentation also indicated the initial ML 104 was billed and paid for date of service 02/13/2013 causing this Med legal exam to be outside of nine months from the Initial ML. Therefore, Claims Administrator was justified in reducing ML 101 to ML 102 and no further reimbursement is recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of code ML 101 is not warranted.

Date of Service: 2/12/2014						
Medical-Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML 102	\$1125.00	\$625.00	\$500.00	1	\$625.00	DISPUTED SERVICE: No reimbursement recommended.

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