

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 26, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0002003	Date of Injury:	11/15/2010
Claim Number:	[REDACTED]	Application Received:	12/31/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML 106		

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,

Paul Manchester, MD, MPH
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: Labor Code Section 10606

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 code ML 106
- Claims administrator denied code indicating on the Explanation of Review “We cannot review his service without necessary documentation. Please resubmit with indicated documentation as soon as possible.” Claims administrator does not state any specific documentation to be submitted.
- Pursuant Labor Code Section 10606: All medical-legal reports shall comply with the provisions of Labor Code Section 4628. Except as otherwise provided by the Labor Code, including Labor Code Sections 4628 and 5703, and the rules of practice and procedure of the Appeals Board, failure to comply with the requirements of this section will not make the report inadmissible but will be considered in weighing the evidence.
- Provider submitted a half page document with five lines titled “Supplemental Report Medical Legal Fee Schedule Explanation of billing ML 106 Supplemental Report Time Spent: 0:45” Nothing in this document supplements the initial findings. ML 106 is used when the provider adds additional diagnosis(s) or recommendations because the information that determined these/this new finding was not available at the time of the initial exam. The provider does not add anything but concurs with the original findings.
- Based on information reviewed, provider’s “report” does not qualify for ML 106 and therefore reimbursement is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 106 is not recommended.

Date of Service: 6/26/2014							
Medical Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
ML 106	\$185.00	\$0.00	\$185.00	3	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

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