

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

October 20, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001527	Date of Injury:	05/03/2014
Claim Number:	[REDACTED]	Application Received:	09/01/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/20/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106-94		

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 \$195.00 for the review cost and \$3,033.75 in additional reimbursement for a total of \$.A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$3,033.75 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,

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
- 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 seeking remuneration for ML 106-94 service on 04/20/2015.
- Claims Administrator reimbursed Provider \$2,968.75 and then re-cooped funds for service.
- Provider was requested to review additional medical records of a patient that he evaluated one month prior to this date of service 04/20/2015 and provide a supplemental report of the records and of any changes to Provider's previous opinion.
- ML106: Supplemental medical-legal evaluations: 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.
- § 9793 (m) "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.

- Original report of the AME evaluation and CMS 1500 form billing ML 104-94 on date of service 03/09.2015 was submitted for review.
- Supplemental Report documenting “I spent 9.5 hours reviewing records and preparing and proofreading this report” and CMS 1500 form billing ML 106-94 was also submitted for review.
- Opportunity for Claims Administrator to Dispute Eligibility was sent on 9/29/2015. A response from Claims Administrator was not received for this review.
- Based on information reviewed, reimbursement of ML 106-94 is warranted.
- Provider was also charged a fee for the returned check in the amount of \$65.00 which Claims Administrator is responsible to reimburse Provider.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 106-94**

<b>Date of Service:</b> 04/20/2015						
[REDACTED]						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 106-94	\$2,968.75	\$0.00	\$3,033.75	38	\$3,033.75	<b>See Analysis</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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[REDACTED]  
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