

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 29, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001773	Date of Injury:	02/22/2013
Claim Number:	[Redacted]	Application Received:	10/01/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	04/11/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-95-25, 98523-59, 72020, and 72100		

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: N/A
- 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 seeking remuneration of billed codes ML104-95-25, 98523-59, 72020, and 72100.
- Claims Administrator denied all billed codes indicating on the Explanation of Review “Workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment”
- Provider billed codes on a CMS 1500 form. Box #17 was left blank for a name or referring provider or other source.
- Provider’s report submitted titled State Panel Qualified Medical Evaluation for date of service April 11, 2015.
- Provider’s SBR states “The State Panel QME was requested and authorized by Defense Attorney on February 18, 2015, see attached copy of authorization”.
- An authorization or request for services was not identified in this review.
- Title 8, CCR, Section 9793 - (g) "Medical-legal expense" means any costs or expenses incurred by or on behalf of any party or parties, the administrative director, or the appeals board for X-rays, laboratory fees, other diagnostic tests, medical reports, medical records, medical testimony, and as needed, interpreter's fees, for the purpose of proving or disproving a contested claim. The cost of medical evaluations, diagnostic tests, and interpreters is not a medical-legal expense unless it is incidental to the production of a comprehensive medical-

legal evaluation report, follow-up medical-legal evaluation report, or a supplemental medical-legal evaluation report and all of the following conditions exist:

- (2) **The report is obtained at the request of a party or parties, the administrative director, or the appeals board** for the purpose of proving or disproving a contested claim and addresses the disputed medical fact or facts specified by the party, or parties or other person who requested the comprehensive medical-legal evaluation report. Nothing in this paragraph shall be construed to prohibit a physician from addressing additional related medical issues.
- Without supporting documentation of requested services for date of service 4/11/2015, IBR is unable to render a decision in favor of the Provider. Therefore, reimbursement of disputed codes is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes ML104-95-25, 98523-59, 72020, and 72100.

Date of Service: 04/11/2015					
Medical Legal Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
ML104-95-25, 98523-59, 72020, and 72100	\$3,889.14	\$0.00	\$3,889.14	\$0.00	Refer to Analysis

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