

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 24, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001974	Date of Injury:	12/19/2001
Claim Number:	[REDACTED]	Application Received:	10/26/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/14/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML101		

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 \$2784.37 in additional reimbursement for a total of \$2979.37. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$2979.37 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
- 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 for ML 101 on date of service 04/14/2015.
- Claims Administrator reimbursed \$3403.13 from total billed amount \$6187.50 with rationale “excessive billing, and asserts that approximately 45% of the 66 page report includes commentary outside Provider’s area of expertise”
- Communication to Provider from Claims Administrator in the form of a letter dated April 8, 2015 states the injured worker “is being returned to you for a medical-legal evaluation on April 14, 2015 at 10:00am.” Third paragraph requests “Please re-examine the patient and review the enclosed medical records...provide a supplemental with your medical opinion regarding issues of permanent disability, causation, apportionment, and future medical care.” The letter states who will be allowed at this visit which includes the patient, an approved interpreter and the Provider.
- The letter does not mention any areas in which the Provider is not to discuss regarding the injured worker in the supplemental report nor does the request ask only for the Provider’s “area of expertise.”
- Provider’s report documents his opinion of the injured worker’s condition according to the records reviewed as per request from the Claims Administrator.
- Provider’s report documents time spent as:
  1. Face-to-Face 1 hour 25 minutes

2. Record Review 11 hours 45 minutes
3. Medical Research 2 hours 30 minutes
4. Report Writing 9 hours 0 minutes

**For a Total time of 24 hours 40 minutes or 99 units.**

- ML 101: 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.
- Based on information reviewed, additional reimbursement of ML 101 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 101

<b>Date of Service:</b> 04/14/2015						
<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>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
ML 101	\$6187.50	\$3403.13	\$2784.37	99	\$6187.50	\$2784.37 Due to Provider

Copy to:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Copy to:

[REDACTED]

[REDACTED]

[REDACTED]