

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 15, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002158	Date of Injury:	07/25/2013
Claim Number:	[REDACTED]	Application Received:	11/23/2015
Assignment Date:	12/11/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/06/2015 – 03/06/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106-95		

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: 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 \$500.00 in additional reimbursement for a total of \$695.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$695.00** 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, M.D., M.P.H.
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
- OMFS

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 ML106 Med-Legal Supplementary Report, for date of service 03/06/2015.**
- The Claims Administrator denied services due to “out of network,” and “documentation.”
- Opportunity to Dispute communicated to Claims Administrator on 11/25/2015, response not yet received.
- February 24, 2015 communication from (Legal Party) reflects request for a supplemental report.
- Authorization dated “**03/05/2015**,” signed by Claims Administrator indicates “ML106” service “Approved”
- Although the initial Med-Legal report was not submitted for IBR and the Provider’s AME/QME status cannot be verified, the aforementioned authorization is contractual in nature and reflects the Claims Administrator’s agreement for supplemental reporting relating to ‘ML106’ and the Med-Legal Fee Schedule.
- **CCR § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- **The aforementioned 03/05/2015 Authorization** is contractual in nature, as such, contractual obligations apply pursuant to **LC § 5307.11.**
- **Based on the aforementioned documentation and guidelines, reimbursement for is indicated for ML106 services**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106

Date of Service: 03/06/2015 Med-Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML106	\$500.00	\$0.00	\$500.00	8	\$500.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]