

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 12, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000096	Date of Injury:	03/17/2008
Claim Number:	[REDACTED]	Application Received:	01/22/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/28/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML103		

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, M.D., M.P.H.  
Medical Director

[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

## 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 ML103 services performed on 08/28/2015.**
- The Claims Administrator reimbursed \$875.00 for ML 106 services “based upon additional supporting documentation received.”
- **8 C.C.R. §§ 9793, 9795** Medical-Legal Fee Schedule Proposed Regulations (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.
- **§9793(1)** "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.
- **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.

- A request by Legal Representation or Claims Administrator for purposes of “proving or disproving” was not identified in this review.
- Provider’s report does not document time spent with the patient, review of record or report writing.
- Documentation submitted does not support billed ML 103.
- **Based on the aforementioned documentation and guidelines, no further reimbursement is not warranted.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: ML106**

<b>Date of Service:</b> 10/09/2015						
Med-Legal Services						
<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>
ML106	\$1172.00	\$875.00	\$297.00	14	\$0.00	<b>Refer to Analysis</b>

[REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
 [REDACTED]  
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