

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 6, 2016

██████████  
██████████  
██████████

IBR Case Number:	CB16-0000298	Date of Injury:	01/24/2014
Claim Number:	██████████	Application Received:	02/22/2016
Assignment Date:	03/28/2016		
Claims Administrator:	██████████		
Date(s) of service:	08/04/2015 – 08/04/2015		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	ML101-95		

Dear ██████████

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 \$1,500.00 in additional reimbursement for a total of \$1,695.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$1,695.00** 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: ██████████  
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## 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
- Med Legal Official Medical Fee Schedule

## 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 disputing \$0.00 reimbursement for ML101-95 services performed on 08/04/2015.**
- Claims Administrator denied services indicating: "Payment denied/reduced for absence of, or exceeded, pre-certification/authorization."
- **ML101 Med. Legal Definition:** "*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
- **Modifier-95 Med. Legal Definition:** "Evaluation performed by a panel selected Qualified Medical Evaluator."
- **Authorization** dated June 2, 2015 from (Legal Parties) confirms Provider's "QME" status as a "Panel Qualified Medical Examiner," and re-evaluation date of 08/04/2015.
- Provider is a Qualified Medical Examiner under California Labor Code Section 139.2.
- Authorization for Physician to "re-examine" Injured Worker and additional records. Authorization specifically asks Provider to advise parties in the following areas:
  - Causation
  - Diagnosis
  - Periods of TTD or/and T.P.DD; P&S date

- Impairment discussion and impairment percentage (please include and Almaraz/gusman discussin to ascertain most accurate W.P.I.).
- Apportionment (for defendant)
- Need for continuing or future medical care.
- November 18, 2014 (Initial QME Exam as per documentation) to August 3, 2015 is 261 days. This is equal to 8 months and 19 days which is less than 9 month time frame for ML101 reporting.
- Abstracted Information and time frame qualifies for ML101-95 service.
- 13 units indicated = \$812.50 Due Provider for ML101-95 services.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for ML101-95**

Date of Service: 08/04/2015							
Med Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML101-95	\$1,500.00	\$0.00	\$1,500.00	N/A	24	\$1,500.00	Refer to Analysis

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