
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 31, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000378	Date of Injury:	08/25/2015
Claim Number:	[REDACTED]	Application Received:	03/04/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/10/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106		

[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 \$375.00 in additional reimbursement for a total of \$570.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$570.00** 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

[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 additional remuneration ML106 Supplemental Med-Legal Report for service date 04/10/2015.**
- The Claims Administrator denied ML 106 with the following rationale: "Review of records by primary treating physician are only billable per evaluation and management code per labor code 5307.1."
- Communication from Legal Party to Provider, "thank you for acting as Panel Qualified Medical Evaluator..." then states additional records for Provider's review and to "Please prepare a supplemental report and answer the following questions." Attorney lists three questions for Provider to focus on in his report.
- CMS 1500 indicates ML106.
- Provider documents on SBR "Dr. is the Panel QME #1615357, she is not the treating physician. She is the panel QME per LC4062.2."
- Not identified in review is any supporting documentation stating the Provider is the primary treating physician.
- Opportunity for Claims Administrator to Dispute was sent on 3/7/2016. A response from Claims Administrator was not received for this review.
- §9795 ML 106 - Fees for supplemental medical-legal evaluations. 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 or portion thereof, rounded to the nearest quarter hour, spent by the physician.

