

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 23, 2016

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

IBR Case Number:	[REDACTED]	Date of Injury:	02/11/2014
Claim Number:	[REDACTED]	Application Received:	04/28/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/08/2016		
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: 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,

Maximus

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

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 02/08/2016.**
- The Claims Administrator denied ML 106 with the following rationale: “submitted documentation does not support the service being billed for.”
- Communication from Claims Examiner dated **January 19, 2016** to Provider states, “**Request for supplemental** Thank you for agreeing to see the above referenced employee on 12/17/2015 in the capacity of a Qualified Medical Evaluator selected from a panel issued by the DWC Medical Unit”. Claims Administrator then lists 9 directives for Provider to address which included a thorough comprehensive history, clinical examination, disability, nonindustrial factors and whether any permanent disability exists.
- Request was for a “Supplemental,” and directives refer to a face-to-face evaluation of the injured worker.
- Provider documents on the submitted report “On January 22, 2016 I received from the claims administrator’s January 19, 2016 letter and attached medical records regarding the applicant” and proceeds to list the records that were reviewed.
- Claims Administrator’s letter dated January 19, 2016 does not mention any attached documents for the Provider to review and submit a report.
- § 9792.5.7 (b) unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested

liability or the applicability of a contract for reimbursement rates under Labor Code 5307.11 shall be resolved before seeking independent bill review.

- **Based on the aforementioned documentation and guidelines, reimbursement for ML106 is not warranted.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106

Date of Service: 02/08/2016 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML106	\$125.00	\$0.00	\$125.00	2	\$0.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]