

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 29, 2016

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

IBR Case Number:	CB16-0000900	Date of Injury:	08/15/1981
Claim Number:	[REDACTED]	Application Received:	05/31/2016
Assignment Date:	06/21/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/09/2015 – 12/09/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043, 93000, and 93306		

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
- Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations
- Med-Legal 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 85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043, 93000, and 93306 submitted for date of service 12/09/2015.**
- The Claims Administrator denied services with the following rationale:
  - “Bill reviewed by nurse... “
  - “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
  - “Reimbursement included in the Value of the Medical Legal Evaluation.”
- Directives outlining Med-Legal services requested 06/23/2016 from Provider post IBR Assignment date, 06/21/2016; response received 06/27/2016. Provider indicates “the issue submitted for review **is whether the diagnostic tests are included in the value of a comprehensive medical-legal evaluation, not whether the services were authorized to be performed.**” (Emphasis added)
- **Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations, § 9794. Reimbursement of Medical-Legal Expenses, (a)** The cost of comprehensive, follow-up and supplemental medical-legal evaluation reports, diagnostic tests, and medical-legal testimony, regardless of whether incurred on behalf of the employee or claims administrator, shall be billed and reimbursed as follows:
  - (1) X-rays, laboratory services and other diagnostic tests shall be billed and reimbursed in accordance with the official medical fee schedule adopted pursuant to Labor Code Section 5307.1. In no event shall the claims administrator be liable for the cost of any diagnostic test provided in connection with a comprehensive medical-legal evaluation report unless the subjective complaints and physical findings that warrant the necessity for the test are included in the medical-legal evaluation report. Additionally, the claims administrator shall not be liable for the cost of diagnostic tests, absent prior authorization by the claims administrator, if **adequate medical information is already in the medical record provided to the physician.** (Emphasis added).
- **§ 9794 - Reimbursement of Medical-Legal Expenses (e)** If after completion of the second review process under Labor Code section 4622 (b)(1) the physician still contests the amount paid for the medical-legal expense, **the physician shall only contest the amount to be paid** by requesting independent bill review as provided in Labor Code section 4603.6. (Emphasis added).
- Since the Claims Administrator asserts the tests are “included in the Value of the Medical Legal Evaluation,” and directives outlining the type of Med-Legal Services requested were not received, and it is unknown if “**adequate medical information**” was submitted to the Provider for the requested Med-Legal service, a decision as to whether or not 85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043, 93000, and 93306 are included in the value of (this) Med-Legal evaluation, cannot be determined through IBR without adequate documentation outlining the expected services. Additionally, the Provider indicates these services are included, which contradicts the Claims Administrator’s reason for denial.
- Without documentation to support the Provider’s position that 85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043,

93000, and 93306 services are part of the ordered service that the Claims Administrator deems inclusive to the corresponding Med-Legal Examination, reimbursement cannot adequately be determined.

- Since the services, and not the amount of reimbursement (**\$ 9794**), are contested, and directives from the Claims Administrator and/or Legal Parties were not submitted for review to substantiate the services, reimbursement cannot be determined.
- **Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043, 93000, and 93306.**

The table on below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043, 93000, and 93306**

<b>Date of Service:</b> 12/09/2015					
<b>Med-Legal</b>					
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
85025, 80061, 84481, 84439, 84443, 36415, 80048, 80076, 84550, 82977, 82728, 82306, 82172 x 2, 83036, 82570, 82043, 93000, and 93306	\$618.34	\$0.00	\$618.34	\$0.00	<b>Refer To Analysis</b>

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