MAXIMUS Federal Services

MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 22, 2021

REDACTED
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IBR Case Number	CB20-0001829
Claim Number	REDACTED
Assignment Date	02/18/2021
Claims Administrator	REDACTED
Date(s) of service	10/27/2020 - 10/27/2020
Provider Name	REDACTED
Employee Name	REDACTED
Disputed Codes	ML102-95
Date of Injury	04/28/2020
Application Received	12/23/2020

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: 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 $180.00 for the review cost and $625.00 in additional reimbursement for a total of $805.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$805.00** 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,

MAXIMUS Federal Services

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
- 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 is seeking remuneration for ML102-95 submitted for date of service 10/27/2020.**
- Opportunity to Dispute Eligibility was communicated with the Claims Administrator on 02/02/2021. Response not yet received.
- CMS 1500, place of service 11
    - ML102-95
- EORs reflect zero reimbursement with the rationale: Workers 'compensation claim adjudicated as non-compensable. Carrier not liable for claim or service / treatment.
- **Criteria for ML102**: A basic medical evaluation which does not meet the criteria of any other medical-legal evaluation.
    - Paid at a flat rate; $625.00 per Evaluation, all expenses are included except for diagnostic testing
- **CCR § 9793,** (h) Medical-legal expense:
    - (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.
    - (3) The report is capable of proving or disproving a disputed medical fact essential to the resolution of a contested claim, considering the substance as well as the form of the report, as required by applicable statutes, regulations, and case law.
- Letter from the Claims Administrator indicates: "Thank you for agreeing to evaluate the above-referenced patient in the role of a QME Examiner for the examination date of 10/27/2020, with reference to the patient's denied claim against [Name Redacted] for the left shoulder and neck."
- QME report page 2 indicates: "This report has been prepared pursuant to the provisions of 8 Cal. Code Regulations § 9795 (b) & (c) as a ML 102-95-Basic Comprehensive Medical-Legal Evaluation conducted by a Qualified Medical Evaluator. My opinions are based on my best medical judgment, to a reasonable medical probability. I certify under penalty of perjury that face-to-face time with the applicant was 1.0 hours."
- Provider was requested to perform a med-legal evaluation by a legal party. Report submitted substantiates a ML102-95. **ML102-95 Overturned.**
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for ML102-95.**

The table(s) below describe the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML102-95
Date of Service: 10/27/2020
Med-Legal

Service Code	ML102
Provider Billed	$625.00
Plan Allowed	$0.00
Dispute Amount	$625.00
Assist Surgeon	N/A
Units	1
Workers’ Comp Allowed Amt.	$625.00
Notes	**Overturn** $625.00 (OMFS) **$625.00** **Due Provider** Refer to Analysis

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