

MAXIMUS FEDERAL SERVICES, INC.

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



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

IBR Case Number:	CB16-0000450	Date of Injury:	06/13/2012
Claim Number:	[REDACTED]	Application Received:	03/17/2016
Assignment Date:	04/05/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/25/2015 – 10/25/2015		
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,

Paul Manchester, M.D., M.P.H.
Medical Director

[REDACTED]

[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
- 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: ML106 Medical Legal Supplementary Report submitted for date of service 10/25/2016.**
- EOR's indicate service denied in full.
- **ML106 Definition:** Supplemental medical-legal evaluations: Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.
- Opportunity to Dispute Eligibility communicated with Claims Administrator on 03/18/2016. Response received 04/04/2016. The Claims Administrator indicates the Provider's Tax Identification Number (TIN#) and not the Entity (Business Name) TIN# is required for review of payment. Additionally, the Entity, unlike the Provider, is "not certified by the Medical Board of Chiropractor Examiners to provide professional services," pursuant to Title 16 of the CA Code of Regulations. The CA further asserts "the Fictitious Business name statement does not substitute for a State of California Board of Chiropractic Examiners Certificate of Registration." The communication "invites" the Provider to re-submit ML106 charges under a personal TIN#.
- The request from (Legal Parties) dated 08/26/2015, requested a "supplemental report." The communication is addressed to an individual Provider and not a Group Entity or Fictions Business Name.

- **Administrative Rules Article 5.5.0. § 9792.5.7.** Requesting Independent Bill Review (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 section 5307.11 shall be resolved before seeking independent bill review. (Emphasis added)
- The Claims Administrator disputes obligation of payment to Entity/Fictions Business for ML106.
- The determination of a relevant TIN# or legitimacies relating to a Fictitious Business Name cannot be determined through IBR.
- **Based on the aforementioned documentation and guidelines, reimbursement for ML106 cannot be determined.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106

Date of Service 10/25/2015							
Med-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
ML106	\$1,000.00	\$0.00	\$1,000.00	N/A	16	\$0.00	Refer to Analysis

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