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

May 5, 2016

[redacted]

IBR Case Number:	CB16-0000594	Date of Injury:	09/10/2013
Claim Number:	[redacted]	Application Received:	04/13/2016
Claims Administrator:	[redacted]		
Date(s) of service:	10/29/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	ML102		

[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 $263.48 in additional reimbursement for a total of $458.48. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$458.48** 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

Cc: [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 seeking remuneration for ML102 Med Legal services performed on 10/29/2015.**
- The Claims Administrator based reimbursement on 99215, Established Patient Evaluation and WC003 with rationale "Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service"
- Authorization for ML102 – ML104 services signed by Claims Administrator on 6/3/15, as "Approved."
- **LC § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates **different from those in the fee schedule**, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code **shall not apply to the contracted reimbursement rates.**
- The aforementioned 6/3/15 documentation is contractual in nature. As such, the contractual rates apply pursuant to LC § 5307.11. Unless otherwise indicated, PPO discounted rates are not applicable to Med-Legal fee schedule.
- ML102 OMFS Definition: A basic medical evaluation which does not meet the criteria of any other medical-legal evaluation. Paid at a flat rate ($625.00). All expenses are included except for diagnostic testing.

- Page 6 of submitted "Permanent and Stationary Report" documents evaluation for date of service 10/29/2015. .
- **Based on the aforementioned documentation and guidelines, reimbursement is supported for ML102.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML102

Date of Service: 10/29/2015 Provider Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
99215 WC003	$625.00	$361.52	$263.48	1	$625.00	**$263.48 Due Provider** **Refer to Analysis**

[redacted]

[redacted]

[redacted]