

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 8, 2016

██████████
████████████████████
████████████████████

IBR Case Number:	CB16-0000049	Date of Injury:	02/27/2014
Claim Number:	██████████	Application Received:	01/12/2016
Claims Administrator:	████████████████████		
Date(s) of service:	10/08/2015		
Provider Name:	████████████████████.		
Employee Name:	████████████████████		
Disputed Codes:	ML104-95		

Dear ██████████

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 \$5,000.00 in additional reimbursement for a total of \$5,195.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$5,195.00 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,

Paul Manchester, MD, MPH
Medical Director

cc: ██████████
████████████████████

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
- Official Medical Fee Schedule
- Negotiated contracted rates: PQME Agreement
- National Correct Coding Initiatives

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 ML 104-95 performed on date of service 10/08/2015.
- Claims Administrator denied service with rationale “Alternative services were available and should have been utilized”
- Communication from Claims Administrator to the injured worker, and cc’d Provider, dated August 04, 2015 documents injured workers appointment time and approved location.
- CMS 1500 form submitted shows a different address, however, this is the billing address.
- Provider’s report documents “Examination Location” and matches that on the authorization form.
- Provider’s report also states “This is my Panel Qualified Medical Re-Evaluation of the above-named individual who was seen at my office in authorized location”
- Provider documents 1 hour face-to-face with the applicant, 5 hours on record review, 2 hours on medical research, and 12 hours on report preparation for a total of 20 hours.
- Abstracted from Provider’s Qualified Medical Re-Evaluation report: Causation and Apportionment along with Medical Research in the Appendix:
Pursuant 9795 – ML 103, (3) Two or more hours of medical research by the physician; An evaluator who specifies complexity factor (3) must also provide a

list of citations to the sources reviewed, and excerpt or include copies of medical evidence.

- Based on aforementioned documentation, reimbursement of ML 104 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code ML 104-95

Date of Service: 10/08/2015						
Medical Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML 104	\$5,000.00	\$0.00	\$5,000.00	80	\$5000.00	\$5000.00 Due to Provider

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