

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 7, 2016

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IBR Case Number:	CB16-0000423	Date of Injury:	12/17/2015
Claim Number:	██████████	Application Received:	03/14/2016
Claims Administrator:	████████████████████		
Date(s) of service:	12/17/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	ML104		

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 \$6,250.00 in additional reimbursement for a total of \$6,445.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$6,445.00 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

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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 12/17/2015.
- Claims Administrator denied ML 104 with indication “Alternative services were available and should have been utilized”
- After research of Provider’s Fictitious Business Name, IBR was able to identify Provider’s FBN which shows filed March 14, 2013 and showing an expiration date five years from the date on which it was filed.
- According to 2415: 2415. (a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or **corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, (which Safety Works Inc. does hold)** or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.
- Communication from legal party to Provider, dated November 11, 2015 requesting Provider as a Panel Qualified Medical Evaluator for the injured worker on December 7, 2015.

- Evaluation Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:
 - (1) 2 or more hours Face-to-Face time – **“1 hour face-to face with applicant.”**
 - (2) 2 or more hours Record Review – **“12 hours.”**
 - (3) Two or more hours of medical research by the physician; Med. Legal OMFS, “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 relied upon” **2 hours** –The “Appendix,” at the end of the report documents medical research reviewed.
 - (4) “Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor.”
 - (5) “Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as **three complexity factors.**” **Criteria Met**
 - (6) Causation – “Addressing the issue of medical causation, upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation.” **Criteria Met page 20 of QME Report.**
 - (7) Apportionment – **Criteria Met page 20 of QME report.**
 - (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances; **Criteria Not Met.**
 - (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation. **Criteria Not Met**
 - (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610. **Criteria Not Met, Date of QME 12/17/2015.**
- Based on aforementioned guidelines, Medical Research is not considered a factor in this case.
- Five (5) complexity factors necessary for ML 104 which were identified in Provider’s QME report.
- Based on aforementioned documentation and guidelines, reimbursement of ML 104 is warranted.

The table below describes the pertinent claim line information.

