

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 23, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-000057	Date of Injury:	09/03/2014
Claim Number:	611339	Application Received:	01/14/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	09/17/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	ML104-95		

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, MD, MPH
Medical Director

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
- Official Medical Fee Schedule
- Negotiated contracted rates: N/A
- 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 09/17/2015
- Claims Administrator denied service based on “alternative services were available and should have been utilized.”
- Appointment confirmation communicated from Claims Administrator to Provider for Panel QME was identified in review. Authorization was given to Provider to evaluate the injured worker at his office in Lawndale, CA on September 17, 2015.
- Provider’s QME report submitted documents the injured worker was evaluated at the Provider’s Van Nuys, CA office on 09/17/2015.
- Claims Administrator authorized a specific location based on an “accreditation process” with that particular location to ensure the facilities’ compliance with State and Federal Safety and Health Standards as well as HIPAA regulations.
- Pursuant Title 8 §34 Appointment Notification and Cancellation: (a) Whenever an appointment for a comprehensive medical evaluation is made with a QME, the QME shall complete an appointment notification form by submitting the form in Section 110 (QME Appointment Notification Form)(See, 8 Cal. Code Regs. Â§ 110). The completed form shall be postmarked or sent by facsimile to the employee and the claims administrator, or if none the employer, within 5 business days of the date the appointment was made. In a represented case, a copy of the completed form shall also be sent to the

attorney who represents each party, if known. Failure to comply with this requirement shall constitute grounds for denial of reappointment under section 51 of Title 8 of the California Code of Regulations.

- (b) The QME shall schedule an appointment for the first comprehensive medical-legal examination which shall be conducted **only at the medical office listed on the panel selection form**. Any subsequent evaluation appointments may be performed at another medical office of the selected QME if it is listed with the Medical Director and is within a reasonable geographic distance from the injured worker's residence.
- Pursuant Title 8 Article 2.6 QME Office Locations: (a) Subject to the restriction in Labor Code section 139.2(h)(3)(B) of 10 offices for conducting comprehensive medical-legal evaluations, QMEs who perform comprehensive medical-legal evaluations at more than one physician's office location shall be required to pay an additional \$ 100 annually per additional office location. Each physician's office listed with the Medical Director must be located within California, be identified by a street address and any other more specific location such as a suite or room number, and must contain the usual and customary equipment for the type of evaluation appropriate to the QME's medical specialty or scope of practice. Nothing in this section shall prevent a QME from adding additional offices up to the maximum set forth in Labor Code section 139.2 (h)(3) (B).
- Provider needed to communicate a change in location to Claims Administrator prior to the evaluation to verify authorization approved and none was identified in this review.
- Reimbursement of ML 104-95 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: 09/17/2015					
Medical Legal					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
ML 104	\$8,812.50	\$0.00	\$8,812.50	\$0.00	Refer to Analysis

[REDACTED]

[REDACTED]