
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 1, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000185	Date of Injury:	04/12/2012
Claim Number:	[REDACTED]	Application Received:	02/09/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/20/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML104-95		

[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 \$5,500.00 in additional reimbursement for a total of \$5,695.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$5,695.00 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, M.D., M.P.H.
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
- Medicare Billing Manual
- Med-Legal 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 ML104 services submitted for date of service 07/20/2015.**
- The Claims Administrator denied ML104 indicating “Charge exceeds the Official medical Fee Schedule Allowance.”
- Communication from legal party to Provider dated June 16, 2015 requesting Panel Qualified Medical Evaluation appointment 7/20/2015 on above named injured worker.
- **Evaluation Documentation compared to ML104 OMFS “4 or more complexity factors” requirement:**
 - (1) 2 or more hours Face-to-Face time – **Criteria Met, “2 hours face-to face with applicant.”**
 - (2) 2 or more hours Record Review – **Criteria Met, “6 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” **Criteria Not Met** – (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” **Criteria Not Met** – in accordance with §9793 (j): "Medical research" is the investigation of medical issues. It includes investigating and reading medical and scientific journals and texts. "Medical research" does not include reading or reading about the Guides for the Evaluation of Permanent

Impairment (any edition), treatment guidelines (including guidelines of the American College of Occupational and Environmental Medicine), the Labor Code, regulations or publications of the Division of Workers' Compensation (including the Physicians' Guide), or other legal materials.”

- Due to aforementioned guidelines, Medical Research will not be considered a factor in this Medical Legal review.
- (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.” **Criteria Met**
- (5) “Six or more hours spent on any combination of **three** complexity factors (1)-(3), which shall count as three complexity factors.” **Criteria Not 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 07/20/2015.**
- **Four (4) Complexity Factors Abstracted From QME Report. Five Complexity Factors = ML104.**
- Opportunity for Claims Administrator to Dispute Eligibility sent on 2/10/2016. Response from Claims Administrator not received for this review.
- **Based on the aforementioned documentation and guidelines, ML104 reimbursement is warranted.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML104

Date of Service: 07/20/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML104	\$5,500.00	\$0.00	\$5,500.00	88	\$5,500.00	\$5,500.00 Due to Provider

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

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