

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 31, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000371	Date of Injury:	11/25/2014
Claim Number:	[REDACTED]	Application Received:	03/03/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/17/2015		
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: 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 \$3,250.00 in additional reimbursement for a total of \$3,445.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3,445.00 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

[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: 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 11/17/2015.
- Claims Administrator denied ML 104 with indication “workers compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment”
- Communication from Claims Administrator to Provider, requesting Provider as a Qualified Medical Evaluator for the injured worker’s appointment date 11/17/2015 was identified in this review.
- Provider’s report documents 1 hour face-to-face with the applicant, 2 hours on medical research, and 10 hours on record review/report preparation for a total of 13 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 – 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.”

- Based on aforementioned guidelines, Medical Research is not considered a factor in this case as citations were not identified in the Provider's report.
- Abstracted from Provider's Qualified Medical Evaluation report: Causation and Apportionment. Report qualifies as ML 104.
- Four (4) complexity factors necessary for ML 104 and were identified in Provider's report.
- Based on aforementioned documentation, reimbursement of ML 104 is warranted.

The table below describes the pertinent claim line information.

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

Date of Service: 11/17/2015						
Medical Legal Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
ML 104	\$3250.00	\$0.00	\$3250.00	52	\$3250.00	\$3250.00 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]