

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 9, 2016

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

IBR Case Number:	CB16-0000817	Date of Injury:	08/01/2015
Claim Number:	[REDACTED]	Application Received:	05/16/2016
Assignment Date:	06/02/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/28/2015 – 10/28/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	ML106		

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 \$625.00 in additional reimbursement for a total of \$820.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$820.00** 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,

MAXIMUS

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
- 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 ML106 services submitted for date of service 10/28/2015.**
- EOR indicate services denied to “insufficient information” required to adjudicate claim.
- Opportunity to Dispute Eligibility communicated with the Claims Administrator on 05/17/2016; response received not yet received.
- **ML106 Supplemental Medical-Legal Evaluation.** The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for **supplemental reports** following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.
 - \$63.50/15 min or \$240.00/hr
- Communication from the Claims Administrator, dated 09/29/2015, verifies the Provider agreed to “reexamine” the Claimant in the capacity of QME. Page 2, Paragraph 3, the acknowledgement direct the Provider to “prepare a detailed written report...”
- **The submitted report does not fit the Criteria of a “supplemental” report** as the QME was asked to ‘reexamine’ the patient and to generate a new report (not to expound on the initial examination), and to determine causation of a “**new workers compensation claim for an injury on 8/1/2015.**”
- Based on the directives generated by the Claims Administrator, Med-Legal Examination involving extraordinary circumstances, was requested.
- Document entitled “Fee Justification” indicates the following regarding Record Review, Medical Research, and Report Preparation:
 - 10/28/2015 5 hours
 - 10/29/2015 6.2 hours
- § 9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony (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.
- ML103/ML104: 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.
 - The Exact hours spent on medical research cannot be extrapolated from the submitted ‘Fee Justification,’ and a list of citations pertaining to references research was not submitted for IBR.
 - Fee Justification indicating Time spent on Record Review and Medical Research reflect accumulative time. These Complexity Factors for ML103/ML104 - Record Review and Medical Research, require separate accountability in terms of time.

- **The criteria for ML103/ML104 services has not been met.**
- **ML101 Follow-up Medical-Legal Evaluation criteria is not met** as the Claims Administrator indicates on page 1, paragraph 4 of the QME acknowledgment letter, “**The purpose of this examination is to determine the cause of his August 1, 2015 claimed injury to the low back,**” which is after the initial evaluation of a **separate claim relating to the QME evaluation on 07/15/2015** for “low back and abdomen.”
- The documentation clearly indicates a Med-Legal evaluation was requested and subsequently performed. However, the necessary criteria has not been provided for Med-Legal evaluations 1, 3, 4 & 6. Submitted documentation supports ML102 services.
- **ML102 - Basic Comprehensive Medical-Legal Evaluation.** Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.
- **Based on the aforementioned documentation, reimbursement is not indicated for ML106, recommend reimbursement as ML102.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: ML106

Date of Service: 10/28/2015					
Med-Legal					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
ML106	\$3,625.00	\$0.00	\$3,625.00	\$625.00	Flat Rate Refer to Analysis

Copy to:

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

 [REDACTED]
 [REDACTED]
 [REDACTED]