

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 1, 2016

██████████
████████████████████
████████████████████

IBR Case Number:	CB16-0000167	Date of Injury:	04/29/2015
Claim Number:	██████████	Application Received:	02/04/2016
Claims Administrator:	████████████████████		
Date(s) of service:	10/08/2015		
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 \$3,437.50 in additional reimbursement for a total of \$3,632.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3,632.50 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

cc: ██████████
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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 10/08/2015.
- Claims Administrator reimbursed ML 104 as ML 103 with rationale “services rendered appear to be best described by this code”
- After much research for 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 Claims Administrator to Provider, dated September 18, 2015 requesting Provider as a Panel Qualified Medical Evaluator for the injured worker on October 8, 2015.

