INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 31, 2014

<table>
<thead>
<tr>
<th>IBR Case Number:</th>
<th>CB14-0001514</th>
<th>Date of Injury:</th>
<th>10/11/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Number:</td>
<td></td>
<td>Application Received:</td>
<td>10/09/2014</td>
</tr>
<tr>
<td>Claims Administrator:</td>
<td></td>
<td>Assignment Date:</td>
<td>11/07/2014</td>
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<tr>
<td>Provider Name:</td>
<td></td>
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<tr>
<td>Employee Name:</td>
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<td></td>
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<tr>
<td>Disputed Codes:</td>
<td>490</td>
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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,

[Redacted]

Medical Director

cc: [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: PPO Contract
- 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 is dissatisfied with reimbursement of DRG 490.
- Claims Administrator reimbursed $9375.77 indicating on the Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- Documentation received included a separate dispute by the Claims Administrator which states “The requested invoices are not available, as the provider did not submit invoices to us with the billing. Implants would not be payable with this billing per the CA fee schedule. The bill was priced to pay according to DRG 491, rather than the billed DRG 490. The billed DRG 490 (Back & Neck proc. Exc. spinal fusion w/cc/mcc or disc device/neurostim) is not appropriate as the cc/mcc is not supported. The diagnosis billed to support this is 30401, which is not documented to have had an effect on the stay, surgery, or consumption of services of this patient. It is not mentioned until the discharge summary from the hospital. This did not prolong or make the surgery more labor intensive. Therefore, the more appropriate DRG is 491 (Back and neck proc. Exc. spinal fusion w/o cc/mcc) which is how the bill was paid.”
- Upon review of the operative report submitted, provider documents procedure performed. Nothing is mentioned about any complications or comorbidities of the patient in this report to substantiate DRG 490. Maximus requested copies of implant invoices, however, none were received.
Based on information reviewed, Claims Administrator was correct in reimbursement of DRG 491. Therefore, additional reimbursement is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 490 is not recommended.

<table>
<thead>
<tr>
<th>Date of Service: 7/09/2014</th>
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<tbody>
<tr>
<td><strong>Hospital Inpatient</strong></td>
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<tr>
<td>Service Code</td>
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<tr>
<td>DRG 490</td>
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Copy to: