

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

---

**Independent Bill Review Final Determination Upheld**

3/11/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: B [REDACTED]  
Date of Disputed Services: 1/11/2013 – 1/15/2013  
MAXIMUS IBR Case: CB13-0000357

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/30/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- 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
- Other: OMFS Inpatient Hospital Fee Schedule

**Supporting Analysis:**

The dispute regards the payment amount for inpatient hospital services 1/11/2013 – 1/15/2013. The Provider billed services and supplies related to the DRG 455. The Claims Administrator paid \$79,164.47 for the inpatient services indicating "The charge exceeds the Official Medical Fee Schedule allowance, the charge has been adjusted to the scheduled allowance. This charge was adjusted to comply with the rate and rules of the contract indicated."

The Provider submitted a claim for inpatient hospital services and is requesting additional reimbursement for the implantable hardware billed under Revenue code 278 and DRG 455.

For discharges occurring on or after January 1, 2013 but before January 1, 2014, an additional allowance of \$9,140.00 shall be made for spinal devices used during complex spinal surgery MS-DRGs 453, 454, and 455; an additional allowance of \$3,170.00 shall be made for spinal devices used during complex spinal surgery MS-DRG 456; and an additional allowance of \$670.00 shall be made for spinal devices used during complex spinal surgery MS-DRGs 028, 029, and 030, per California Code of Regulations, Title 8 Section 9789.22(g)(2). Based on the date of service and DRG, an additional allowance of \$9,140.00 for the implantable hardware is warranted.

The OMFS Inpatient Hospital Fee Schedule maximum payment amount is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20 and by making any adjustments required in California Code of Regulations, Title 8 Section 9789.22.

Based on a review of the documentation, the inpatient services were reimbursed based on PPO contract. The Claims Administrator's explanation of review (EOR) indicated a payment of \$79,164.47 and a PPO discount of \$4,166.52. According to the EOR, the inpatient services billed under the DRG 455 were paid according to the Official Medical Fee Schedule and the PPO contract for the dates of service 1/11/2013 – 1/15/2013.

There is no additional reimbursement warranted per the Official Medical Fee Schedule Inpatient Hospital Services DRG 455.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

| Validated Code | Dispute Amount | Total Fee Schedule Allowance | Provider Paid Amount | Allowed Recommended Reimbursement | Fee Schedule Utilized |
|----------------|----------------|------------------------------|----------------------|-----------------------------------|-----------------------|
| DRG 455        | \$31,214.94    | \$79,164.44                  | \$79,164.47          | \$0.00                            | PPO contract          |

**Chief Coding Specialist Decision Rationale:**

This decision was based on OMFS Inpatient Hospital Fee Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$79,164.47 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[REDACTED], RHIT

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]