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

Independent Bill Review Final Determination Reversed

2/13/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 2/21/2013 – 2/23/2013
MAXIMUS IBR Case: CB13-0000492

Dear [redacted],

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/20/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of $335.00 and the amount found owing of $9,597.51, for a total of $9,932.51.**

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
- Official Medical Fee Schedule or negotiated contract: OMFS
- Other: OMFS Inpatient Hospital Fee Schedule

Supporting Analysis:
The dispute regards the payment amount for inpatient hospital services 2/21/2013 - 2/23/2013. The Provider billed services and supplies related to the DRG 491. The Claims Administrator paid $2,850.00 for the inpatient services and denied any further allowance on the request for second review indicating "No additional reimbursement allowed after review of appeal/reconsideration/request for second review."

The Provider submitted a claim for inpatient hospital services and is requesting additional reimbursement for the inpatient services billed under the DRG 491.

The operative report documented procedures: L4-L5 left hemilaminectomy with partial medial facetectomy and diskectomy; Left L5-S1 hemilaminectomy with partial medial facetectomy.

Based on a review of the explanation of review (EOR), the Claims Administrator made a payment of $2,850.00, and applied a PPO discount of $3,527.81. MAXIMUS requested a copy of the PPO contract. The PPO contract was not received. It does not appear the PPO discount was applied to the correct OMFS Inpatient Hospital Allowance for the DRG 491. The EOR did not indicate any other reason or denial code more specific than “Charge exceeds the Official Medical Fee Schedule allowance. The Charge has been adjusted to the scheduled allowance." The additional allowance and/or recommendation for the inpatient services billed under DRG 491 were calculated based on the Official Medical Fee Schedule Inpatient Hospital Fee Schedule.

The Inpatient Hospital Fee Schedule for California Workers' Compensation maximum payment amount is determined by multiplying the DRG weight x hospital composite factor x 1.20 per California Code of Regulations, Title 8 Section 9789.21(o).

The additional reimbursement of $9,597.51 is warranted per the Official Medical Fee Schedule Inpatient Hospital Fee Schedule DRG code 491.

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

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
DRG 491	$10,479.71	$12,447.51	$2,850.00	$9,597.51	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**$335.00**) and the OMFS amount for DRG code 491 ($9,597.51) for a total of $9,932.51.

The Claims Administrator *is required to reimburse the provider $9,932.51 within* ***45 days of date on this notice per section 4603.2 (2a).*** *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

[redacted]

Copy to:

[redacted]