

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 6, 2015

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001481	<b>Date of Injury:</b>	09/21/2009
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/02/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	11/07/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	DRG 454		

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 \$250.00 for the review cost and \$16,001.19 in additional reimbursement for a total of \$16,251.19. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$16,251.19 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,

[Redacted]  
[Redacted]

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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- 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 454, Inpatient Services.
- Claims Administrator reimbursed claim indicating on the Explanation of Review “CBR and Workers’ Compensation Jurisdictional Fee Schedule Allowance.”
- Provider states they are due \$16,001.19 and goes on to mention: “Furthermore, there was an improper PPO discount taken. Our contract with First Health does not provide a discount from the Official Medical Fee Schedule”
- PPO contract submitted states “Inpatient Outlier Provision: If charges for a single uninterrupted inpatient stay, less charges reimbursed under a separate rate category, are greater than \$52,093, reimbursement for that stay only will be at a 20% discount from charges in lieu of the contract rate.”
- Hardware invoices must include documented paid costs, net of discounts and rebates, plus any sales tax and/or shipping and handling charges paid. Provider’s invoices only document hardware and unit price. Provider did not submit the appropriate invoices to determine an Outlier Cost and therefore would not qualify for the Outlier.
- Additional allowance for spinal devices used in complex spinal surgery: (2) For discharges occurring on or after January 1, 2013 but before January 1, 2014, an additional allowance of \$9,140 shall be made for spinal devices used during complex spinal surgery

