

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 12, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001913	Date of Injury:	04/25/2014
Claim Number:	[REDACTED]	Application Received:	12/11/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 490		

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,

Paul Manchester, M.D., M.P.H.
Medical Director

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

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 remunerating for DRG 490 Back & Neck Proc Exc Spinal Fusion W CC/MCC Or Disc Device/Neurostim Rehabilitation Services provided to Injured Worker from 08/18/14 – 08/19/14.**
- Claims Administrator reimbursement rational: “The charge has been adjusted to the scheduled allowance.”
- UB-04 Reflects the following diagnoses: 722.10 Displacement of lumbar intervertebral disc without myelopathy; 272.4 Other Unspecified Hyperlipidemia; and 304.01 Opioid type dependence, continuous.
- Pre-Operative Note 08/18/2014 states, “no changes from most recent history and physical,” noting regular heart rate and clear lungs & pulse WNR.
- Operative Note 08/18/2014 states, “no complications.”
- Operative Note 08/18/2014 does not indicate a Neurostim Implantation and/or Device as indicated with DRG 490 description.
- Post-Operative Note 08/18/2014 states, “no complications.”
- Discharge Summary (Electronically signed 8/26/2014) states the following: “complications during the hospitalization **none**.”
- Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, section 9789.24, pertaining to Inpatient Hospital Fee Schedule in the Official Medical Fee Schedule, is adjusted to conform to the final rule of August 19, 2013 and the corrections of

October 3, 2013, January 2 and 10, 2014, and the interim final rule of October 3, 2013, published in the Federal Register, which changes the Medicare payment system. Amended section 9789.24 reflects Medicare’s changes to the Relative Weights and Geometric Mean Length of Stay for the listed Medicare Severity diagnosis-related groups. §9789.20 (d) “The Inpatient Hospital Fee schedule shall be adjusted to conform to any relevant changes in the Medicare payment schedule...”

- Presented diagnoses 722.10 Displacement of lumbar intervertebral disc without myelopathy; 272.4 Other Unspecified Hyperlipidemia; and 304.01 Opioid type dependence, continuous are not listed in Medicare’s **Table 6J** – Complete CC list - FY 2014 or **Table 6I** – Complete Major CC list - FY 2014.
- Operative Note does not reflect spinal device or implantation.
- DRG 490 is not indicated without a qualifying primary diagnosis code from **Table 6J** or **Table 6I** and/or spinal device or implantation.
- Based on the aforementioned documentation and guidelines, DRG 490 is not supported.
- Documentation supports DRG 491.
- DRG 491 Wt. 1.0893 x Hosp. Comp. Factor 7796.33 x WC Multiplier 1.20 = \$10,191.05
- It appears the Claim Administrator’s reimbursement is based on DRG 491 Back & Neck Proc Exc Spinal Fusion WO CC/MCC; additional compensation is not indicated.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: DRG 490

Date of Service: 08/18/2014 – 08/19/2014						
Inpatient Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
DRG 490	\$79,559.57	\$10,191.05	\$7,439.57	N/A	\$10,191.05	Refer to Analysis

Copy to:

[Redacted]

Copy to:

[Redacted]