

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 24, 2015

██████████
██████████
████████████████████

IBR Case Number:	CB15-0001444	Date of Injury:	08/15/2011
Claim Number:	██████████	Application Received:	08/24/2015
Claims Administrator:	████████████████████		
Date(s) of service:	01/21/2015 – 01/24/2015		
Provider Name:	████████████████████		
Employee Name:	████████████████████		
Disputed Codes:	DRG 472		

Dear ██████████

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, MD, MPH
Medical Director

cc: ██████████
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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: Partial 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 472, cervical fusion w CC.
- Claims Administrator down coded DRG 472 indicating on the Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated” and ”The documentation does not support the level of service billed”
- Request for Authorization was not identified for this review nor was Utilization Review Approved services.
- Provider billed REV Code 0360 (along with other REV Codes) on a UB04. However, the HCPCS/CPT code was not identified for 0360 (or a few others).
- Provider states Claims Administrator removed ICD-9 code 263.1; malnutrition of mild degree.
- Provider’s Operative report submitted does not mention malnutrition. Furthermore, appropriate and accurate documentation with the presence of one or more MCC or CC is not indicated.
- The level of severity of illness under the MS-DRG system is determined by the presence or absence of the CCs and MCCs. A diagnosis with CC or MCC is not established to qualify DRG as 472.

