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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 8, 2016

[redacted]

IBR Case Number:	CB16-0000795	Date of Injury:	09/08/2011
Claim Number:	[redacted]	Application Received:	05/12/2016
Claims Administrator:	[redacted]		
Date(s) of service:	03/03/2015 – 03/06/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	DRG 460		

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 $195.00 for the review cost and $3,786.78 in additional reimbursement for a total of $3,981.78. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $3,981.78 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,

Maximus

cc: [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: N/A
- National Correct Coding Initiatives
- Other: IPPS

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 seeking remuneration of DRG 460 performed on dates of service 03/03/2015 – 03/06/2015
- Claims Administrator reimbursed $38,254.03 with rationale "your billing has been paid in accordance with the Inpatient Fee Schedule."
- Contractual Agreement not submitted for review.
- **§9789.20**. General Information for Inpatient Hospital Fee Schedule—Discharge On or After July 1, 2004.
  - (a) This Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule covers charges made by a hospital for inpatient services provided by the hospital.
- **§9789.22**. Payment of Inpatient Hospital Services:
  - (a) Unless otherwise provided by applicable provisions of this fee schedule, the maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the hospital's composite factor and the applicable DRG weight and by making any adjustments required by this fee schedule. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a hospital for inpatient medical services not exempted under this section
  - Inpatient Hospital Fee Schedule maximum payment amount (**DRG weight x 1.2 x hospital specific composite factor**).

- Inpatient hospital claim reimbursed per DRG weight x 1.2 x CF:
    - 3.9998 x 1.2 x 8758.94 = $42,040.81
- Based on guidelines and regulations, additional reimbursement is warranted for DRG 460.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code DRG 460

Date of Service: 03/03/2015 – 03/06/2015				
Provider Billed	**Plan Allowed**	**Dispute Amount**	**Workers' Comp Allowed Amt.**	**Notes**
$144,345.30	$38,254.03	$3,786.78	$42,040.81	$3,786.78 Due to Provider

Copy to:

[redacted]

Copy to:

[redacted]