

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 24, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000549	Date of Injury:	07/19/2004
Claim Number:	[Redacted]	Application Received:	04/08/2014
Claims Administrator:	[Redacted]	Assignment Date:	06/30/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	DRG 030		

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 \$670.00 in additional reimbursement for a total of \$920.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$920.00 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]
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
- Negotiated contracted rates: PPO Contract
- National Correct Coding Initiatives
- Other: Title 8 CCR §9789.22 OMFS Payment of Inpatient Hospital Services

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 30.
- Claims Administrator reimbursed \$1200.00 indicating on the Explanation of Review “Your facility has a superseding preferred provider contract with [REDACTED] network. Therefore, the charges were reduced using the network discount.” Contract reviewed states “Reimbursement for both inpatient and outpatient services, including all exclusions and stop loss calculations, provided to Workers’ Compensation patients shall not exceed 100% of the state mandated fee schedule in force at the time of treatment.”
- Pursuant §9789.22 Payment of Inpatient Hospital Services: (f) (1) Cost Outlier cases. Inpatient services for cost outlier cases shall be reimbursed as follows: Step 1: Determine the Inpatient Hospital Fee Schedule maximum payment amount (DRG weight x 1.2 x hospital specific composite factor). Step 2: Determine costs. Costs = ((total billed charges - charges for spinal devices) x total cost-to-charge ratio)) + **documented paid spinal device costs, net of discounts and rebates, plus any sales tax and/or shipping and handling charges actually paid.**
- Provider did not submit appropriate invoice for paid spinal devices. Therefore, Outlier reimbursement is not recommended.

- Under (g) (2) of §9789.22 Payment of Inpatient Hospital Services: (g) 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 \$670 shall be made for spinal devices used during complex spinal surgery MS-DRGs 028, 029, and 030.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the Official Medical Fee Schedule Inpatient Hospital Fee Schedule, additional reimbursement of DRG 30 is warranted.

Date of Service: 11/21/2013-11/22/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
DRG 30	\$30349.59	\$1200.00	\$ 16286.56	1	\$670.00	DISPUTED SERVICE: Allow reimbursement \$670.00.

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