

**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**

December 5, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0000564	<b>Date of Injury:</b>	10/1/2001
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	04/11/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	06/20/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	DRG289		

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,

[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

## 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 disputing reimbursement for Hospital Service Code DRG 289 for Date of Service 08/10/2013 – 08/18/2013.
- Claims Administrator **1<sup>st</sup> EOR “Approved” Date 11/20/2013** indicated, “We cannot review this service without necessary documentation. Please re-submit with indicated documentation as soon as possible,” indicating payment of \$40,478.86 pending requested documentation for Rev Code 278.
- **2<sup>nd</sup> EOR “Approved” Date 03/17/2014** indicates the Provider was reimbursed \$39, 8298.86 of \$40,578.86 billed charges.
- Remaining Balance of \$750.00, on 2<sup>nd</sup> EOR indicates \$0.00 reimbursement for supplies and implants (Rev Code 278) denied by the Claims Administrator stating, “We cannot review this service without necessary documentation. Please re-submit with indicated documentation as soon as possible.”
- Contractual Agreement, “Attachment A-2,” provided for IBR states “\*\*Stoploss: For only one admission incurring over \$40,000 (\$60,000 for CVS) in total charges, thereafter reimbursement shall be at 75% of billed charges for the entire stay in lieu of the above rates.”
- Total billed charges indicated on UB04 for 8/10/2013 – 08/15/2013 Admission = \$40,578.86.
- Provider reimbursed = \$39, 8298.86
- 75% of \$40,578.86 = \$30, 434.15

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: DRG289**

<b>Date of Service:</b> 08/10/13 – 08/15/2013							
<b>In Patient Hospital</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
DRG 289	\$40,578.86	\$39,8298.86	\$3,605.30	N/A	1	\$39,8298.86	<b>PPO Contract</b>

Copy to:

[REDACTED]

Copy to:

[REDACTED]