

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 1, 2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000585	Date of Injury:	09/19/2013
Claim Number:	[REDACTED]	Application Received:	04/16/2014
Claims Administrator:	[REDACTED]	Assignment Date:	06/20/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 454		

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
- Negotiated contracted rates: PPO Contract Discount
- National Correct Coding Initiatives
- Other: OMFS Inpatient Hospital 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's Request for Second Bill Review states "Payments received not in accordance with Outpatient Fee Schedule."
- Claim received on a UB04 with Type of Bill #111 – Regular Inpatient.
- Based on review of the operative report Provider performed Combined Anterior/Posterior Spinal Fusion W CC – DRG 454. Report documents Admit Date: 02/12/2014 and Discharge Date 02/17/2014.
- Pursuant Title 8, California Code of Regulations OMFS Inpatient Hospital Fee Schedule:
(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.

- (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).OM; 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 any invoices for cost of implants and therefore an Outlier Cost is unable to be determined.
- Claims Administrator reimbursed \$67,117.70 indicating on Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- PPO Contract reviewed shows an 8% discount agreement which was applied as documented on the Explanation of Review.
- Based on the Inpatient Hospital Service formula less the PPO Discount, Claims Administrator was correct in reimbursement and therefore no further payment is due to Provider.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of DRG code 454 is not warranted.

Date of Service: 2/12/2014						
Inpatient Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
DRG 454	\$228,342.76	\$67,117.70	\$161,225.06	1	\$67,117.70	DISPUTED SERVICE: No reimbursement recommended.

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