

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 25, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000629	<b>Date of Injury:</b>	09/27/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	04/18/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	06/23/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	DRG 464		

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 \$25726.46 in additional reimbursement for a total of \$25976.46. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$25976.46 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]  
[Redacted]

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: None
- National Correct Coding Initiatives
- Other: OMFS Inpatient Hospital Fee Schedule
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## **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 464.
- Claims Administrator reimbursed \$20597.18 stating on the first Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated.” Claim was resubmitted for a second review and denied further reimbursement based on Explanation of Review “It appears that the bill was previously reviewed and paid to the CA Inpatient Hospital Fee Schedule – Outlier factor @ \$51198.37 however there was PPO reductions with a HealthSmart PPO contract of \$30601.19 = \$20597.18.”
- PPO Contract received and reviewed states: “Workers’ Compensation – Workers’ Compensation reimbursement rates shall be at one hundred percent (100%) of the California State Workers Compensation Fee Schedule.”
- Based on review of the operative report submitted, Provider performed DRG 464 - WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC.

- Title 8 California Code of Regulations, Official Medical Fee Schedule – Inpatient Hospital Fee Schedule March 15, 2013, §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.
- DRG 464 has a reimbursement of \$46323.64 based on all variables submitted by the Provider. Provider should have been reimbursed 100% of DRG amount pursuant to contract received. No PPO discount for Workers’ Compensation claims is documented.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of DRG code 464 is warranted.**

<b>Date of Service:</b> 3/19/2014							
<b>Inpatient Hospital Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers’ Comp Allowed Amt.</b>	<b>Notes</b>
DRG 464	\$270195.66	\$20597.18	\$30601.18	N/A	N/A	\$25726.46	<b>DISPUTED SERVICE:</b> Allow reimbursement \$25726.46.

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