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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 22, 2015

[redacted]

IBR Case Number:	CB14-0001679	**Date of Injury:**	05/12/2011
Claim Number:	[redacted]	**Application Received:**	11/07/2014
Claims Administrator:	[redacted]	**Assignment Date:**	12/04/2014
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: 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 $5,686.88 in additional reimbursement for a total of $5,936.88. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $5,936.88 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]

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
- Partial Contractual Agreement: 92% Inpatient 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 seeking full remuneration for Inpatient Services billed as DRG 454 for dates of service 08/20/2014 – 08/23/2014.
- Claims Administrator Reimbursement Rational as follows: "The amount paid reflects fee schedule reduction."
- UB 04 Submitted, Bill Type "0111," Hospital In-Patient, Admit.
- DRG 454 Combined Anterior/Posterior Spinal Fusion W CC Operative report states
- Operative Note indicates "Complications: None"
- Based on the documentation reimbursement recommended for DRG 455 Combined Anterior/Posterior Spinal Fusion W/O CC/MCC
- **§9789.22. (g)(3)** "For discharges occurring on or after January 1, 2014, complex spinal surgery DRGs shall not receive any additional or separate reimbursement for spinal devices, unless the Administrative Director extends section 9789.22(g)(2) to discharges occurring on or after January 1, 2014, in accordance with Labor Code Section 5307.1(m) through a later enacted regulation."
- Dates of service 08/20/2014 – 08/23/2014; additional payment for spinal devices are not allowed.

- **§9789.21. (O) '** "Inpatient Hospital Fee Schedule maximum payment amount" is that amount determined by multiplying the DRG weight x hospital composite factor x 1.20 and by making any adjustments required in Section 9789.22."
  DRG 455 6.2882 x Hospital Composite 7796.33 x WC Multiplier 1.20 = $59,810.36.

  The table below describes the pertinent claim line information

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 454 is warranted.

Date of Service: **08/20/2014 – 08/23/2014**						
Hospital Inpatient Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Unit**	**Workers' Comp Allowed Amt.**	**Notes**
DRG 454	$271,747.96	$54,123.48	$14,905.85	1	$59,810.36	**Reimburse as DRG 455 – Reimbursed Amount = $5,686.88 Due Provider**

Copy to:

[redacted]

Copy to:

[redacted]