

**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**

September 17, 2015

██████████  
██████████  
██████████████████

IBR Case Number:	CB15-0001434-A	Date of Injury:	12/16/2011
Claim Number:	██████████	Application Received:	08/24/2015
Claims Administrator:	██		
Date(s) of service:	03/10/2015 – 03/13/2015		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	DRG 455		

Dear ██████████

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 \$195.00 for the review cost and \$13,131.00 in additional reimbursement for a total of \$13,326.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$13,326.00 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,

Paul Manchester, MD, MPH  
Medical Director

cc: ██████████  
██

## 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 Agreement
- National Correct Coding Initiatives

## 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 spinal fusion device on date of service 3/13/15.
- Claims Administrator reimbursed \$26,262.00 with indication on the Explanation of Review “This bill has been repriced according to your PPO contract with the network”
- Partial contact received states “spinal fusion device cap = \$39,393.00”. Compensation rates portion of contract states “Hospital shall bill for the spinal fusion procedure and spinal fusion device on hospital billing form UB04 or its successor form. Payment for the spinal fusion procedure and device is based on ICD-9 CM Code 81.00-81.08, and combined with Revenue Codes 274 or 278.”
- Provider billed Rev Code 278 and ICD-9 CM Code 81.07.
- §5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.

- Opportunity for Claims Administrator to Dispute letter was sent on 8/28/2015. A response from Claims Administrator has not been received for this review.
- Based on the aforementioned, additional reimbursement is warranted for the spinal fusion device.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code C1713**

<b>Date of Service:</b> 03/10/2015 – 03/13/2015					
<b>Inpatient Services</b>					
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
C1713	\$274,767.90	\$26,262.00	\$13,131.00	\$39,393.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$13,131.00

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