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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 30, 2015

[redacted]

IBR Case Number:	CB15-0001538	Date of Injury:	04/15/2004
Claim Number:	[redacted]	Application Received:	09/03/2015
Claims Administrator:	[redacted]		
Date(s) of service:	02/25/2015 – 02/27/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	DRG 461		

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 $195.00 for the review cost and $75,604.55 in additional reimbursement for a total of $75,799.55. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $75,799.55 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: [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: 90% Billed Charge 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 DRG 461 and is seeking remuneration according to the contract agreement for dates of service 02/25/2015 – 02/27/2015.
- Claims Administrator originally reimbursed $41,722.55.
- With additional reimbursement in the amount of $4,635.86 paid to Provider after this dispute was filed, a total of $46,358.41 per IPPS for DRG 461.
- Provider submitted one page of a PPO contract agreement between Provider and Claims Administrator which states: "Claims Administrator and Provider enter into this agreement under the following terms and conditions: 1. 90% of the current billed charges will be agreed to as the "adjusted billed charge" on all claims process by Claims Administrator"
- Claims Administrator did not dispute contract received for this review.
- § 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.

- Based on documentation reviewed, additional reimbursement is warranted per PPO contract.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 461 per contract agreement.

Date of Service: 02/25/2015 – 02/27/2015					
Inpatient Services					
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Workers' Comp Allowed Amt.**	**Notes**
DRG 461	$135,514.40	$46,358.41	$75,604.55	$121,962.96	**PPO Contract**

Copy to:

[redacted]

Copy to:

[redacted]