

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 23, 2015



IBR Case Number:	CB15-0001981	Date of Injury:	06/15/2009
Claim Number:	[REDACTED]	Application Received:	10/26/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/19/2015 – 5/22/15		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 470		

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 \$8,394.45 in additional reimbursement for a total of \$8,589.45. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$8,589.45 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: Contract Agreement

## 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 implant contract amount in addition to the DRG 470 reimbursement.
- Claims Administrator reimbursed \$11,181.55 with Explanation “This charge was adjusted to comply with the rate and rules of the contract indicated.
- Plan Compensation Schedule from PPO contract states for Inpatient and Outpatient Services: “For Covered Services involving an implant carve-out payment, the total implant charges shall be separated from the non-implant charges for the purposes of applying the following lesser of calculation. Implant charges shall be paid at the lesser of (a) the Network Rate for the implant(s) or (b) Facility’s Eligible Billed charges for the implant(s)”
- Contract shows for inpatient implants effective 4/1/2015, inpatient knee replacement implant shall be 100% of eligible billed charges up to a maximum of \$8600.00 for ICD-9 procedure codes 81.54, 00.60 AND Revenue Codes: 0274, 0278. Provider billed \$10,320.00 for Revenue Code 278.
- Provider submitted ICD-9 procedure code 81.54 and Rev Code 278 on the UB04 for dates of service 5/19/2015 – 5/22/2015 (3 days).
- Opportunity for Claims Administrator to Dispute letter was sent on 10/27/2015. A response from Claims Administrator was not received for this review.
- As codes submitted fall within the contract agreement, additional reimbursement of DRG 470 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 470**

<b>Date of Service: 05/19/2015 – 05/22/2015</b>					
<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>
DRG 470 & Revenue code 278	\$63,371.10	\$11,181.55	\$11,181.55	\$ 19,576.00	<b>DISPUTED SERVICE:</b> Allow reimbursement \$8,394.45

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