

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 10, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002110	Date of Injury:	03/25/2014
Claim Number:	[REDACTED]	Application Received:	11/16/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/22/2015 – 04/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 520		

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 \$9,147.04 in additional reimbursement for a total of \$9,342.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$9,342.04 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]
[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: 92% PPO Reimbursement
- 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 seeking remuneration for DRG 520, BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC performed on 04/22/2015 – 04/23/2015

- Claims Administrator reimbursed \$1000.00 for billed DRG indicating “California Workers’ Compensation inpatient rules applied per DRG listed.”
- Article 5.3 Official Medical Fee Schedule—Inpatient Hospital Fee Schedule as of March 5, 2015 §9789.20. General Information for Inpatient Hospital Fee Schedule—Discharge On or After July 1, 2004. (a) This Inpatient Hospital Fee Schedule section of the Official Medical Fee Schedule covers charges made by a hospital for inpatient services provided by the hospital. (b) Charges by a hospital for the professional component of medical services for physician services rendered on or after January 1, 2014, shall be paid according to Sections 9789.12.1 through 9789.19. Services rendered on or after July 1, 2004 but before January 1, 2014 shall be paid according to Sections 9789.10 through 9789.11. Services rendered after January 1, 2004 but before July 1, 2004 are governed by the “emergency” regulations that were effective on January 2, 2004. Services rendered on or before January 1, 2004 will be paid according to Section 9790, et seq. (c) Sections 9789.20 through 9789.25 shall apply to all bills for inpatient services with a date of discharge on or after July 1, 2004. Services for discharges after January 1, 2004, but before July 1, 2004 are governed by the "emergency" regulations that were effective on January 2, 2004. Bills for services with date of admission on or before December 31, 2003 will be reimbursed in accordance with Section 9792.1.

- **Maximum Allowable Fees:** To determine the standard payment rate, the hospital-specific composite rate would be multiplied by the DRG relative weight and 1.20 multiplier. Additional payments will be made for high cost outlier cases and for certain pass-through costs in accordance with the regulations.
- **Opportunity for Claims Administrator to Dispute** letter was sent on 11/19/2015. A response from Claims Administrator was not received for this review.
- Based on aforementioned guidelines, additional reimbursement is warranted for DRG 520.
- Partial PPO contract received shows an 8% discount is to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 520

Date of Service: 04/22/2015 – 04/23/2015					
Inpatient Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
520	\$70,866.77	\$1000.00	\$9,147.04	\$10,147.04	\$9,147.04 Due to Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]