

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 30, 2015



IBR Case Number:	CB15-0000591	Date of Injury:	06/29/2009
Claim Number:	[REDACTED]	Application Received:	4/17/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	05/14/2015		
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 \$195.00 for the review cost and \$22,245.75 in additional reimbursement for a total of \$22,440.75. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$22,440.75 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]

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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
- National Correct Coding Initiatives
- Other: OMFS Inpatient Hospital Fee Schedule

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: Reimbursement of inpatient services billed with DRG 454.**
- Claims Administrator reimbursement rational: “DRG reimbursement is based on new DRG code.”
- DRG 454: Combined anterior/posterior spinal fusion w CC
- Based on a review of the EOR, Provider was reimbursed for DRG 455: combined anterior/posterior spinal fusion w/o cc/mcc.
- Medical record substantiated the billed DRG 454.
- Billed Diagnoses and POA indicators:
 - 722.52 Lumb/lumbosac disc degen (DRG) POA: Yes, present at the time of inpatient admission
 - 995.93 SIRS-noninf w/o ac or ds (CC) (DRG) POA: No, not present at the time of inpatient admission
 - 401.9 Hypertension NOS POA: Yes, present at the time of inpatient admission
 - 722.10 Lumbar disc displacement POA: Yes, present at the time of inpatient admission

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- 600.01 BPH w urinary obs/LUTS POA: Yes, present at the time of inpatient admission
- 788.20 Retention urine NOS POA: No, not present at the time of inpatient admission
- 275.2 Dis magnesium metabolism POA: No, not present at the time of inpatient admission
- Billed Procedure codes:
 - 81.06 Lumb/lmbosac fus ant/ant (DRG) (OR)
 - 81.07 Lmb/lmbsac fus post/post (DRG) (OR) 8051 Excision intervert disc (OR)
 - 80.54 Rep anuls fibros NEC/NOS (OR) 8162 Fus/refus 2-3 vertebrae
 - 84.51 Ins spinal fusion device
- Medical record substantiated the billed procedures as performed.
- Hospital Medicine Progress Note 11/1/2014 Assessment and Plan, #1 Degenerative disc disease with central disc protrusion intractable back pain and bilateral foraminal stenosis with radiculopathy, L5-S1 status post anterior lumbar discectomy with interbody fusion, bilateral L5-S1 laminotomy and posterior spinal fusion at L5-S1 with allograft and local bone graft on 10/31/2014. #2. Systemic inflammatory response syndrome with leukocytosis and tachycardia due to number 1.
- Progress Note 11/2/2014: #2 Systemic inflammatory response Temodar syndrome with leukocytosis and tachycardia due to #1. Heart rate improved. WBC slow downward.
- **Systemic inflammatory response syndrome (SIRS)** is defined as a clinical response to an insult, infection, or trauma that includes a systemic inflammation as well as elevated or reduced temperature, rapid heart rate, rapid respiration, and elevated white blood count. According to the American College of Chest Physicians and the Society of Critical Care Medicine, the clinical manifestations of SIRS include:
 - Fever of greater than 100.4 or hypothermia with a temperature of less than 98.6
 - Leukocytosis, white blood cell count of greater than 12,000 cells per cubic millimeter
 - Leukopenia, white blood cell count of less than 4,000 cells per cubic millimeter
 - Tachycardia
 - Hyperventilation
 - Coding for SIRS requires a minimum of two codes: a code for the underlying cause or infection (such as trauma) and a code from subcategory 995.9x, Systemic inflammatory response syndrome.
- Based on the aforementioned documentation and guidelines, reimbursement is indicated for DRG 454.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code DRG 454

Date of Service: 10/31/2014 - 11/3/2014					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes

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DRG 454	\$ 115,700.81	\$ 80,774.75	\$ 22,245.75	\$ 103,020.50	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$22, 245.75 recommended.
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