

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 16, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000925	Date of Injury:	02/20/2008
Claim Number:	[Redacted]	Application Received:	06/08/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	01/21/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	DRG 472		

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 \$21,577.19 in additional reimbursement for a total of \$21,772.19. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$21,772.19 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:
- National Correct Coding Initiatives
- Other: IPPS

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 denial of DRG 472
- Claims Administrator denied code indicating on the Explanation of Review “The documentation does not support the level of service billed”
- Provider billed DRG 472 on a UB-04 for inpatient services. Primary diagnosis code submitted is 722.0 with secondary diagnosis as V85.41 – Body mass index 40.0 – 44.9, adult.
- Diagnosis V85.41 is on the Final Complete Complication or Comorbidities (cc) list.
- DRG 472 – Cervical Spine Fusion W CC
- Provider’s report submitted documents discectomy at C4-5 with a one level surgical plate to the vertebral bodies with screw applied at C4 and C5.
- Title 8, California Code of Regulations Chapter 4.5, Division of Workers’ Compensation Subchapter 1 Administrative Director—Administrative Rules Article 5.3 Official Medical Fee Schedule—Inpatient Hospital Fee Schedule (a) Unless otherwise provided by applicable provisions of this fee schedule, the maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the hospital’s composite factor and the applicable DRG weight and by making any adjustments

required by this fee schedule. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a hospital for inpatient medical services not exempted under this section. However, preadmission services rendered by a hospital more than 24 hours before admission are separately reimbursable.

- Order of the Acting Administrative Director of the Division of Workers' Compensation (OMFS Update for Inpatient Hospital Services-Effective March 15, 2014) Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, section 9789.24, pertaining to Inpatient Hospital Fee Schedule in the Official Medical Fee Schedule, is adjusted to conform to the final rule of August 19, 2013 and the corrections of October 3, 2013, January 2 and 10, 2014, and the interim final rule of October 3, 2013, published in the Federal Register, which changes the Medicare payment system. Amended section 9789.24 reflects Medicare's changes to the Relative Weights and Geometric Mean Length of Stay for the listed Medicare Severity diagnosis-related groups.
- $RW\ DRG\ 472 = 2.4819 \times CF = 7244.85 \times 1.20 = \$21,577.19$
- Provider does document procedure performed and therefore, reimbursement of DRG 472 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of DRG 472

Date of Service: 01/22/2015							
Inpatient Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
DRG 427	\$32,757.81	\$0.00	\$32,757.81	1	N/A	\$21,577.19	DISPUTED SERVICE: Allow reimbursement

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