

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 28, 2015

[REDACTED]

IBR Case Number:	CB15-0001232	Date of Injury:	04/27/2009
Claim Number:	[REDACTED]	Application Received:	07/28/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/16/2015 – 03/06/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 885		

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 \$44,722.89 in additional reimbursement for a total of \$44,917.89. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$44,917.89 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: 67.5% PPO Contract
- 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 billed charges for Inpatient Acute Rehabilitation for depression.
- Claims Administrator reimbursed Provider \$10,231.80 indicating on the Explanation of Review “Your bill has been paid in accordance with the Inpatient Hospital Fee Schedule”. A second payment was made after the SBR was submitted in the amount \$9,576.70.
- The following are exempt from the maximum reimbursement formula set forth in Section 9789.22 (a) and are paid on a reasonable cost basis: (6) Rehabilitation hospital or distinct part rehabilitation units of an acute care hospital or a psychiatric hospital or distinct part psychiatric unit of an acute care hospital
- Partial PPO contract received states “HOSPITAL agrees that in the event a Member, who is covered for worker’s compensation benefits by an Affiliate or under a workers’ compensation arrangement administered by an Affiliate, seeks services for a work-related illness or injury, HOSPITAL shall provide such Hospital Services as are Medically Necessary. As payment for such Hospital Services rendered, HOSPITAL agrees to accept the California Workers’ Compensation fee Schedule. For Hospital Services not subject to the California Workers’ Compensation Fee Schedule, HOSPITAL agrees to accept as payment in full the compensation rates set forth in Exhibit B – Compensation Rates – to this Agreement applicable to the MCS product on the date-of-service. Nothing in this provision shall require

