MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 8, 2016

[redacted]

IBR Case Number:	CB15-0002259	Date of Injury:	06/03/2015
Claim Number:	[redacted]	Application Received:	12/10/2015
Claims Administrator:	[redacted]		
Date(s) of service:	06/03/2015 – 06/06/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	DRG 552		

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 $78,492.62 in additional reimbursement for a total of $78,687.62. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$78,687.62** 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, M.D., M.P.H.
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
- Participating Hospital 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 seeking additional reimbursement for Hospital Inpatient Service DRG 552 billed for service dates 06/03/82015 – 06/06/2015.**
- The Claims Administrator's reimbursement rational indicates, "maximum allowable reached" per "labor code "5307.1."
- UB-04, Bill Type 011 Revenue Codes:
- **Contractual Agreement signed By** the Claims Administrator listed under "PPO Information" of the EORS, indicates the following Percentage allowance from billed charges for **Inpatient Charges: 5%.**
    - Contract does not refer to a "State Mandated Amount" or "Allowed" amount.
    - Contract indicates "Fee Schedule" as "Exhibit A"
    - Exhibit A indicates 5% of billed charges for In Patient Services.
- **Pursuant to LC § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, **the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.**
- Opportunity to Dispute Eligibility communicated to **Claims Administrator** on 12/15/2015; **Additional Contractual Agreement documents disputing the 5% PPO discount allowance of billed charges not yet received**.

- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for In Patient DRG 552.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: DRG 552

Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
DRG 552	$91,766.04	$8,685.12	$76,492.52	N/A	$87,177.74	PPO Contract $78,492.62 Due Provider

Copy to:

[redacted]

Copy to:

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