

**MAXIMUS FEDERAL SERVICES, INC.**

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



---

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

February 23, 2016

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB16-0000134	Date of Injury:	06/12/2014
Claim Number:	[Redacted]	Application Received:	01/29/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	06/13/2014 – 06/19/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	DRG 253		

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 \$9,636.57 in additional reimbursement for a total of \$9,831.57. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$9,831.57 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
- 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 253 for dates of service 06/13/2014 – 06/19/2014
- Claims Administrator down coded DRG 253 other vascular procedures with CC, to 254 other vascular procedures without CC “due to the lack of documentation submitted to support ICD-9 285.1, acute post-hemorrhagic anemia (due to acute blood loss).”
- Provider billed ICD-9 444.22, arterial embolism and thrombosis of lower extremity, and 285.10, both codes on the complete CC list for FY 2014.
- Provider’s documentation dated 6/18/2014 states “hct drop, no obvious source of bleeding. Transfusing 1 unit.” Hct = hematocrit. Anemia refers to an abnormally low hematocrit. Hemorrhagic: pertaining to bleeding or the abnormal flow of blood. The patient may have an internal hemorrhagic problem that is not visible.
- Other Provider documentation states “undergoing thrombolysis now” supporting ICD-9 444.22.
- Based on documentation reviewed, additional reimbursement of DRG 253 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code DRG 253

<b>Date of Service:</b> 06/13/2014 – 06/19/2014					
<b>Inpatient Services</b>					
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
253	\$298,770.98	\$30,273.85	\$9,636.57	\$39,910.42	\$9,636.57 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]