

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 26, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000179	Date of Injury:	06/30/2014
Claim Number:	[REDACTED]	Application Received:	02/08/2016
Claims Administrator:	Liberty Mutual		
Date(s) of service:	07/21/2014 – 07/22/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	DRG 054		

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 \$7,809.09 in additional reimbursement for a total of \$8,004.09. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$8,004.09 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: Contract Agreement
- 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 DRG 054 for dates of service 07/21/2014 – 07/22/2014
- Claims Administrator reimbursement rationale: “This charge was adjusted to comply with the rate and rules of the contract indicated”
- A copy of the PPO contract was reviewed.
- Contract states “4. Section 2.35 of the Agreement is hereby deleted in its entirety and replaced with the following: ‘PPO Rate’ means the lesser of one hundred percent (100%) of Facility’s Eligible Billed Charges for Health Services, or the total reimbursement amount that Facility and Insurance have agreed upon as specified in the Plan Compensation Schedule (“PSC”) attached hereto as Attachment 2. The PPO Rate shall represent payment in full to Facility for Health Services. Notwithstanding the forgoing, Facility shall have the right to collect Cost Shares, coordination of benefit revenue and stop loss recoveries in accordance with the terms of this Agreement.”
- Contract continues: “20. Plan Compensation Schedule (“PCS”) is hereby deleted in its entirety and replaced with the following Attachment 2-Plan Compensation Schedule (“PCS”) attached hereto and incorporated herein by this reference.” Agreement is signed by both parties involved.
- PCS Rate Sheet (MCS) attached shows compensation for services inpatient and outpatient. Inpatient criteria column was reviewed for codes billed by Provider but none

